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THESIS

**A FINANCIAL ANALYSIS OF RESOURCE SHARING
AGREEMENTS AS PART OF THE TRICARE MANAGED
CARE SUPPORT CONTRACTS**

by

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December 1998

Thesis Advisor:

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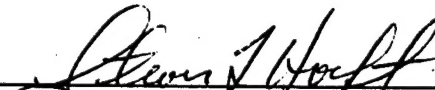
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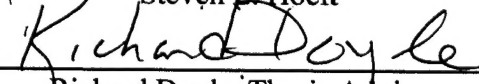
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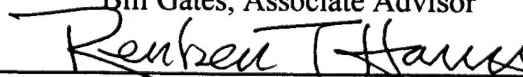

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ABSTRACT

Escalating health care costs and base closures have forced the DoD to improve access to health care while maintaining quality, controlling costs, and increasing medical readiness. The response is a Tri-service managed care system called TRICARE. One mechanism utilized within the TRICARE Managed Care Support Contracts (MCSCs) is Resource Sharing. Resource sharing is a system to reduce the government's health care costs by recapturing the TRICARE workload. This thesis explores if Resource Sharing Agreements (RSAs) are cost-effective and how they are being monitored and evaluated by the Lead Agent and MTFs. After conducting a literature review, interviews and performing data analysis, this thesis examined the reported cost analysis, retrospective analysis, and workload of RSAs in Health Services Region 10 as they are used under the MCSC for that region. A case study of RSAs, comparing forecasted and reported savings, was also conducted to understand RSAs and their role in controlling military health care costs. The analysis found that the RSAs are reducing government costs, but not at the predicted rate. This case study found that only 67 percent of the estimated government savings were realized. Decreasing workload is a key factor explaining this shortfall.

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LIST OF ACRONYMS

ADD	ACTIVE DUTY DEPENDENT
BAFO	BEST AND FINAL OFFER
CHAMPUS	CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES
CHCS	COMPOSITE HEALTH CARE SYSTEM
CPA	CERTIFIED PUBLIC ACCOUNTING
DCP	DATA COLLECTION PERIOD
DOD	DEPARTMENT OF DEFENSE
DRG	DIAGNOSIS-RELATED GROUP
EBC	ENROLLMENT-BASE CAPITATION
FAW	FINANCIAL ANALYSIS WORKSHEET
FHFSI	FOUNDATION HEALTH FEDERAL SERVICES, INC.
GAO	GENERAL ACCOUNTING OFFICE
HMO	HEALTH MAINTENANCE ORGANIZATION
HSR10	HEALTH SERVICES REGION 10
IPA	INDEPENDENT PRACTICE ASSOCIATION
MCSC	MANAGED CARE SUPPORT CONTRACT
MEPRS	MEDICAL EXPENSE AND PERFORMANCE REPORTING SYSTEM

MHS	MILITARY HEALTH SYSTEM
NADD	NON-ACTIVE DUTY DEPENDENT
NAS	NON-AVAILABILITY STATEMENT
OASD(HA)	OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS
OASD(PA)	OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE FOR PUBLIC AFFAIRS
OLA	OFFICE OF THE LEAD AGENT
PCP	PRIMARY CARE PROVIDER
PMPM	PER MEMBER PER MONTH
POS	POINT-OF-SERVICE
PPO	PREFERRED PROVIDER ORGAINZATION
RSA	RESOURCE SHARING AGREEMENT

I. INTRODUCTION

A. BACKGROUND

The primary mission of the Military Health System (MHS) is to maintain the health of 1.6 million active duty service personnel and 6.6 million other military-related beneficiaries, including dependents of active duty personnel, military retirees and dependents. This \$15.5 billion of medical care is provided in about 115 military hospitals and 470 military clinics worldwide, and through supplemented care funded by the Department of Defense (DoD) but provided in civilian facilities [GAO/HEHS 97-130].

Escalating health care costs and base closures have forced the DoD to improve access to health care while maintaining quality, controlling costs, and increasing medical readiness. In December 1993, DoD submitted a plan to the Congress establishing a nationwide managed care plan, referred to as TRICARE. The goals of this plan are to ensure that eligible military beneficiaries have access to stable, high-quality health care benefits and to improve the efficiency of the military health system. To accomplish these goals, DoD proposed a regional approach to delivering and financing health care in the military. This approach is a Tri-service managed care system called TRICARE.

The TRICARE program is managed by the military in partnership with civilian contractors. Each of the 11 regions has a Lead Agent and a multistate managed care support contract. TRICARE is the medical program for active duty members, qualified

family members, non-Medicare eligible retirees and their family members and survivors of all uniformed services. It is designed to expand access to care, assure high quality care, control health care costs for patients and taxpayers alike, and improve medical readiness. TRICARE began March 1995 in Oregon and Washington and is now being implemented by region. It was completely implemented throughout the United States as of June 1998.

TRICARE includes a triple option benefit package; beneficiaries can choose between three TRICARE options - Prime, Extra or Standard. The only option requiring enrollment is TRICARE Prime. TRICARE Prime is an HMO option; TRICARE Extra is a preferred provider option; and TRICARE Standard is a fee-for-service benefit replacing the CHAMPUS program.

At the heart of the TRICARE program are seven large and complex contracts with civilian medical organizations to supplement and support the military-provided health care for the 11 regions. These 5-year contracts, called Managed Care Support Contracts (MCSCs), are to provide innovative and cost saving managed care techniques in conjunction with the Military Treatment Facilities (MTFs). One of the cost saving techniques in the MCSC is the Resource Sharing Agreement (RSA). RSAs are specific agreements to share resources between the MCSC and a MTF in a joint effort to increase access and capabilities and reduce cost.

B. OBJECTIVES OF THIS THESIS

This study will examine of the reported cost analysis, retrospective analysis, and workload of Resource Sharing Agreements as they are used under the MCSC. It includes a case study comparing RSA forecasted savings and reported savings. It will describe RSAs and their role in helping control military health care costs. Specifically, this thesis will examine the process of monitoring and evaluating the RSA after it has been instituted. Furthermore, the monitoring mechanism used in different MTFs will be examined.

C. RESEARCH QUESTIONS

This thesis will examine how RSAs are being monitored and evaluated by the Lead Agent and MTF for cost-effectiveness. The primary research question addresses the following: What is the role of the RSA within the MCSC and how are they being monitored and evaluated for cost-effectiveness? In addition to the primary research question, the following subsidiary questions will be answered:

- What is the purpose of Resource Sharing Agreements?
- Are TRICARE Resource Sharing Agreements achieving the expected cost efficiency?
- How is cost effectiveness defined for Resource Sharing Agreements?
- Is there a standardized method for monitoring Resource Sharing Agreements at different Medical Treatment Facilities?

D. LIMITATIONS

This thesis is limited to examining the experiences of Resource Support Agreements in DoD Health Services Region 10 (HSR10), also known as TRICARE Golden Gate, since the beginning of the Managed Care Support Contract in April 1996. The results of the contractor's (Foundation Health Federal Services) cost analysis and retrospective cost analysis are reported. Their methodology is proprietary and unavailable for review.

E. SCOPE OF THESIS

This thesis will examine the Resource Sharing feature of the MCSC by extensive literature review and a case study of ten RSAs within HSR10. It will focus on the Financial Analysis Worksheet (FAW), contractor prepared cost analysis, retrospective cost analysis and monthly workload of existing RSAs to compare the forecasted savings with the actual figures. Also, the agreement's tracking, monitoring, and reporting will be analyzed.

F. METHODOLOGY

To provide background on practices and policies for using RSAs, we will examine the existing literature on RSAs from the Office of the Assistant Secretary of Defense for Health Affairs (OASD(HA)), HSR10 and General Accounting Office (GAO) reports. The necessary data and information will be collected from HSR10 for this study.

Interviews will also be conducted with key personnel on the HSR10 Business Operations and Regional Analysts' staff.

G. ORGANIZATION OF THESIS

The thesis includes five chapters. The first chapter provides the introduction, the background, a basic overview of the subject matter, the objectives, the research questions, the scope and the methodology that will be used to address the research questions. Chapter II provides background on the MHS and managed health care programs, civilian and military. Chapter III describes RSAs used in the MCSC. Chapter IV discusses the RSA cost analysis. Chapter V provides the summary, conclusions, and recommendations.

II. BACKGROUND

This chapter will provide a brief history and background of civilian managed care programs, the Military Health System, and DoD's managed health care program.

Managed Care is defined as the responsibility and accountability for the health of a defined population.

A. CIVILIAN MANAGED HEALTH CARE PROGRAMS

During this century, the focus of medical care has changed from the general practitioner to the specialist, from the individual practice to the group practice, and from the entrepreneurial individual to the corporate management of medical care [Kongstvedt, 1995]. Some of the key influences on the development of corporate medicine and health maintenance organizations include the enactment of the Medicare and Medicaid laws of 1965; third-party payers imposing additional cost controls in hospitals, such as diagnosis-related groups (DRG), prospective pricing, and a resource-base relative value scale; as well as additional federal support for managed health care programs embodied in the Health Maintenance Organization Act of 1973 [Kongstvedt, 1995].

Managed care programs have evolved in an attempt to control the cost of health care and through increasing free-market competition in the medical care arena. Most of managed care is paid for by a fixed monthly payment to the health care provider, usually set on a per member per month (PMPM) basis, also known as capitation. The amount is

fixed regardless of how much or how little health care is provided. Brief descriptions of some of the civilian managed care programs are presented below.

1. Health Maintenance Organizations (HMO)

The goal of the HMO is to provide affordable health care through a form of managed care, in which the Primary Care Provider (PCP) is assigned to act as gatekeeper to specialists and expensive medical testing. Often subscribers pay a small fixed amount at each visit as a copayment. Patients have variable limits on the choice of doctors.

a. Staff Model

Staff model HMO's hire their own physicians and pay them a salary. They also own their own medical facilities. As a result, they have higher expenses than other HMOs but offer more of a one stop medical care.

b. Group Model

The group model HMO is a health plan that contracts with a group of physicians of various specialties. These physicians usually share facilities, equipment, and support staff within the group.

c. Network Model

The network model HMO contracts with medical groups within a wide geographic region. They typically have a larger list of physicians from which to choose.

d. Independent Practice Association (IPA) model

The IPA model contracts with physicians in private practice to provide care to HMO members. Managed care trained primary care physicians typically administer them.

2. Preferred Provider Organizations (PPOs)

In PPOs, providers are usually organized by networks and offer medical care for a set discounted fee. Various benefits, such as lower co-insurance and better coverage, create incentives for patients to see "preferred" doctors. Patients typically are allowed to use providers other than the "preferred" doctors, but a higher co-insurance or deductible is applied.

3. Point-of service (POS) plans

POS plans provide the greatest flexibility and choice to the patient by allowing the health plan members to use any physician or hospital in the marketplace. As a result of this freedom to choose providers, monthly premiums and copayments may be higher.

This form of health benefit coverage represents an attractive managed care option, especially if there are multiple HMOs in the group. For this plan to be successful, the beneficiaries must be educated and assured that their health care needs will be satisfied effectively within the network or HMO. Traditional HMOs may offer similar benefit options through an out-of-pocket benefit rider or POS option.

4. Fee for Service

A system of reimbursement in which a medical provider charges a patient or medical insurance plan at a specific price for a specific service, and patients are free to choose the provider.

B. MILITARY HEALTH SYSTEM (MHS)

The MHS mission is defined as follows:

The Military Health System (MHS) supports the Department of Defense (DoD) and our nation's security by providing health support for the full range of military deployments and sustaining the health of members of the Armed Forces, their families, and others to advance our national security interests [OASD(HA) MHS Strategic Plan, 1998].

To meet the MHS mission, health care is provided at MTFs with active duty personnel having first priority [Lamar, 1994]. Non-active duty beneficiaries may receive care at MTFs on a space available basis or by utilizing the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) until they qualify for Medicare. CHAMPUS was first instituted in 1966 and provided funding for non-active duty beneficiaries, under the age of 65, for civilian health care.

C. MILITARY MANAGED HEALTH CARE PROGRAM (TRICARE)

TRICARE is the DoD medical program established by the Secretary of Defense in 1994 under the authority of Chapter 55 of Title 10, United States Code, principally section 1097. The program includes the competitive selection of contractors to

financially underwrite the delivery of health care services under CHAMPUS

[Congressional Record, 1996].

TRICARE is DoD's approach to meeting the medical portion of the employee benefit package in the best way possible with today's limited resources. While controlling cost, it is charged with improving access to care and preserving quality [GAO/HEHS 96-128, 1996]. TRICARE was designed to incorporate some of the same cost-control features currently employed by private sector managed care programs—primary care managers, capitated budgeting and utilization management. Civilian contractors will cooperate with the military medical system to provide required care. When Congress approved TRICARE, the intent was that TRICARE must not increase DoD's health care cost [Backhus, 1996].

As illustrated in Table 1, there are seven multi-region MCSCs, worth about \$15 billion over five years [GAO/T-HEHS 98-100, 1998]. The program began in March 1995 with Region 11, encompassing Washington and Oregon; by June 1998, all MCSCs were in place throughout the United States. Although the TRICARE program was originally mandated by law to be fully implemented by September 30, 1996, Congress extended the deadline for its implementation one year, to September 30, 1997 [Joseph, 1996]. However, due to bid protests, regions 1, 2, and 5 commenced in June 1998.

TRICARE contractor	Region covered	5-year contract award amount	Expected start date	Actual start date
Foundation Health Federal Services	Northwest	\$475 million	March 1995	March 1995
Foundation Health Federal Services	Southwest	1.8 billion	November 1995	November 1995
Foundation Health Federal Services	Southern California, Golden Gate, and Hawaii-Pacific	2.5 billion	October 1995	April 1996
Humana Military Healthcare Services	Southeast and Gulf South	3.8 billion	May 1996	July 1996
Triwest Healthcare Alliance	Central	2.3 billion	November 1996	April 1997
Sierra Military Health Services	Northwest	1.2 billion	May 1997	June 1998
Anthem Alliance for Health	Mid-Atlantic and Heartland	3.1 billion	May 1997	June 1998

Table 1¹ TRICARE Contract Implementation Status

Under current law, Medicare-eligible beneficiaries are not eligible for care under TRICARE. Retirees and dependents over the age of 65 do retain eligibility for care on a space available basis in MTFs; however, due to initiation of TRICARE, budgetary constraints, and base closures, this availability is decreasing [Best, 1997]. Pilot studies are being conducted for TRICARE Senior Prime, otherwise known as Medicare Subvention, which will allow Medicare-eligible military retirees and their family members to receive military comprehensive health care services. These Medicare-

¹ Source United States General Accounting Office, Report Number T-HEHS-98-100, February 26, 1998

eligible military retiree beneficiaries must participate in Medicare Part B to be eligible for TRICARE Senior Prime [OASD(PA), 1998].

The failure to consistently provide timely access to care has dissatisfied military beneficiaries for a long-time. Primary care access standards have been established and included in the 1994 TRICARE policy guidelines. DoD current standards for appointment wait times are [GAO-HEHS 96-128, 1996]:

- 4 weeks for well visit (preventive)
- 1 week for routine visit
- 1 day for acute illness care

Under TRICARE, eligible beneficiaries select one of the three health care options. The options differ according to the recipient's choice of provider and out-of-pocket cost. As the level of patient management decreases, choice and cost (to beneficiary and government) increases. In order of decreasing choice and cost, the options are: TRICARE Standard, TRICARE Extra, and TRICARE Prime. Active duty military personnel are automatically enrolled in TRICARE Prime at their nearest MTF.

1. Purpose

The TRICARE program goals and principles are to increase access to care, provide high quality health care at low cost, provide choice to non-active duty beneficiaries, contain DoD health care costs, and maintain a combat-ready force capable of meeting its broad-ranging mission requirements [Updated TRICARE Policy Guidelines, 1994].

2. Capitation

The MHS version of capitation methodology is Enrollment-Based Capitation (EBC). This is a financial arrangement that gives the MTF Commanders full accountability for all resources used by the TRICARE Prime enrolled populations. Under EBC, MTF Commanders know exactly the TRICARE Prime patients for which they are responsible and how much funding they will receive to care for these patients [EBC Handbook, 1998]. In other words, the MTFs are responsible for a defined population at a fixed amount per beneficiary.

There are essentially three primary components of EBC: a per member per month (PMPM) premium earned by the MTF for each TRICARE Prime patient enrolled; additional revenues for providing care for non-TRICARE Prime patients on a space-available basis; and a system of referrals under which the referring MTF is billed for treatment provided TRICARE Prime enrollees who are sent out for specialty care. Revenues and purchased care are reconciled on a monthly basis and could result in funds being transferred within and between the three Military Departments [EBC Handbook, 1998].

3. Managed Care Support Contracts

TRICARE contractors receive fees as part of their compensation for services rendered under a MCSC. Anticipated enrollment fees must be counted in bid prices as an offset to taxpayer dollars from the military health budget. By reducing what DoD pays the contractor, the fees save health service dollars for use in the MTFs. DoD remains in

charge of eligible beneficiaries' care. Contractors are hired to perform specific functions listed in each MCSC. Each region's Lead Agent and MTFs select the functions. While some functions involve limited management tasks, contractors' management discretion is limited by detailed contract instructions.

For example, the contractors manage enrollment, but the MHS controls the standards and conditions of enrollment/disenrollment, fees, etc. The MHS gives contractors enough discretion to use their expertise and business judgement, but not enough to jeopardize the beneficiary's rights and benefits. In other words, contractors manage how the job gets done, but the MCSC precisely defines the contractor's job. Contractors do not manage the overall health-care program. TRICARE contracts are rigorously drafted to ensure military oversight.

Of course, contractors will strive to maximize their profits. That is a normal, healthy aspect of our free enterprise system. But MCSCs are carefully designed so that contractors' financial incentives help the beneficiaries rather than hurt them (i.e., the contractor benefits financially by giving the beneficiary better care and better access, not by cutting corners on either access or quality.)

4. Regions

Under the TRICARE program, the country has been divided into eleven regions as shown on the Figure 1. Each region has a designated Lead Agent charged with administering the MCSC, overseeing and coordinating regional activities, and implementing TRICARE within the region. Lead Agents integrate issues and policies and establish the most effective method to deliver health care to a region [Lamar, 1994]. Command and control of the individual facilities in the region remain with the chain of command for the parent service.



Figure 1. TRICARE Regional Map²

² Source TRICARE Management Activity Homepage
(<http://www.ochampus.mil/ManagedCareSupportContracts>)

Some responsibilities of the Lead Agent identified in the OASD(HA) Policy 96-010, Lead Agent Guidelines, include:

- Support medical readiness and contingency operations
- Develop and execute a Regional Health Services Plan
- Monitor and analyze regional budgets, targets, costs/expenses and enrollment data
- Develop, evaluate and execute the regional MCSC
- Oversee the TRICARE marketing activities for the region
- Coordinate communication among the MTFs within the region as well as up the chain of command
- Promote regional automated information management support systems
- Support professional, managerial and technical training in the region

MTF Commanders are given the tools and authority to make the appropriate decisions about the locally delivered and managed health care. Along with the Lead Agent, they are held accountable for the health care costs, quality, and access in their delivery areas, both in the direct care system and the civilian networks.

5. Triple Option Plan

TRICARE's three benefit options give beneficiaries a choice. These are TRICARE Prime, the HMO option; TRICARE Standard, a fee-for-service benefit replacing the CHAMPUS program; and TRICARE Extra, a preferred provider option

[GAO/T-HEHS 98-100, 1998]. TRICARE rates for the three options are displayed in Appendix A.

a. TRICARE Prime

This is an HMO like option. Some of the managed health care advantages of this option are guaranteed access to care; first priority for care at MTFs; and the assignment of a Primary Care Manager (PCM). PCMs are qualified health care providers or a group of providers who deliver and coordinate the beneficiaries' care, as well as authorize specialty care. Other TRICARE Prime advantages include both a Health Care Finder (HCF), who makes test/specialty appointments for the beneficiary from the TRICARE Service Center, and claims filing. All active duty service members will be automatically enrolled in TRICARE Prime and will continue to receive most of their care from military medical personnel [OASD(HA) What is TRICARE?, 1997].

TRICARE Prime enrollees also have a POS option where the beneficiary may receive non-emergent care without a referral from the PCM. However, there is a deductible and beneficiaries may have to pay additional charges for non-network providers [OASD(HA) What is TRICARE?, 1997].

All Medicare-eligible beneficiaries and those CHAMPUS-eligible beneficiaries who elect not to enroll in TRICARE Prime remain eligible for care in MTFs on a space available basis.

b. TRICARE Extra

TRICARE Extra consists of CHAMPUS-eligible beneficiaries who are not enrolled in TRICARE Prime and are using an authorized civilian preferred network provider. This option offers a discount on services and the beneficiaries' copayment is reduced by five percent from the TRICARE Standard cost shares. However, the annual TRICARE Standard deductible must be met before cost sharing begins. Beneficiaries do not enroll in TRICARE Extra, but may participate on a case-by-case basis by using network providers [OASD(HA) What is TRICARE?, 1997].

c. TRICARE Standard

This is a new name for the traditional CHAMPUS program. In this option, the deductibles, copays and benefits are the same as they were with CHAMPUS [OASD(HA) What is TRICARE?, 1997]. There is no enrollment for this option. As shown in Appendix A, the copayments for TRICARE Standard are higher than the other options, however the beneficiaries are free to select the civilian provider of their choice.

6. National Mail Order Pharmacy

The DoD started a national mail-order pharmacy benefit for eligible beneficiaries on October 1, 1997. As of April 1, 1998, the TRICARE national mail-order pharmacy program was fully operational and had replaced regional mail-order plans operated by individual TRICARE contractors [TRICARE Management Activity, No. 98-8, 1998].

D. OVERVIEW AND SUMMARY

This chapter provided a brief history of managed health care programs in the civilian sector as well as in the military with TRICARE. The MHS and TRICARE strive to provide increased access to high quality health care with a greater freedom of choice, while reducing the overall cost.

The next chapter will focus on one aspect of the MCSC, Resource Sharing, which is intended to be one of the avenues to increase access, increase capabilities, and reduce cost.

III. RESOURCE SHARING AGREEMENT OVERVIEW

This chapter gives a brief overview of Resource Sharing Agreements (RSAs). This is an unique partnership agreement between the MTF and the TRICARE contractor. The MCSC makes these agreements possible and OASD(HA) encourages their use. This partnership reduces the overall cost of the MHS by increasing access to military health care and expanding the military health care services available for beneficiaries, thus decreasing the amount of the more expensive civilian care.

There are some resource sharing changes in the newer MCSC under "revised" financing which are outside the scope of this thesis.

A. PURPOSE

Resource sharing is a system to reduce health care costs to the government by recapturing the TRICARE workload. This is based on the assumption that MTF provided health care is less expensive than care provided by civilian practitioners [Chiang, 1998]. Most MTFs lack the resources (personnel, equipment and supplies) necessary to recapture this workload. This is where resource sharing comes into place. RSAs are agreements allowing the MTF and the TRICARE contractor to share their resources to provide additional services, thus sharing the cost savings which result from this action.

TRICARE gives the MTF Commanders new ways to apply resources to increase the quality and improve the access to health care at an affordable cost. In the forefront of

these new options in the MCSC are resource sharing and resource support, which are designed to increase the efficiency and effectiveness of the MHS by making the best use of available resources to enhance the productivity of the direct care system [OASD(HA) Policy for Resource Sharing and Resource Support, 1996]

Some of the government's savings associated with resource sharing initiatives was the result of the initial TRICARE contract bid price being decreased based on the projected resource sharing savings. Therefore, significant contract savings have already been identified for resource sharing in the form of the lower MCSC bid price [OASD(HA) Policy for Resource Sharing and Resource Support, 1996]. This reduced MCSC bid price saved about \$2 billion dollars [GAO/T-HEHS-98-100, 1998].

Resource sharing is to be considered first to recapture the TRICARE workload. MTF Commanders and the Lead Agents are to make good faith efforts to work with the TRICARE contractors to execute sound RSAs [OASD(HA) Policy for Resource Sharing and Resource Support, 1996].

DoD first estimated that the resource sharing could save \$700 million over five years. However, after 9 to 24 months, the new estimate is only about \$36 million over five years [GAO/T-HEHS-98-100, 1998].

B. RESOURCE SHARING PROPOSALS

MTFs, the TRICARE contractor and the Office of the Lead Agent (OLA) all identify and evaluate potential opportunities for resource sharing [GAO/HEHS-97-130, 1997]. Various reports, MTF self-evaluation and site visits can disclose potential in shortfalls in the demand for medical services.

The contractor has built in incentives to perform Resource Sharing since the bid price was decreased to reflect assumed savings through using RSAs. If these front loaded savings are not realized, serious losses might be incurred. In developing the estimated savings, the MCSC identified potential areas in the bid proposal where RSAs may be beneficial. In addition, the contractor is required to submit an annual Resource Sharing plan that is developed in conjunction with the MTFs and OLA.

Unlike the contractor, the MTFs lack the incentives to participate in resource sharing. The MTFs may not receive any of the savings, and the marginal costs (e.g., pharmacy, supply) associated with the RSA are funded out the MTF's operating budget. However, resource sharing may assist the MTF Commander in maximizing the use of its current resources.

Once opportunities for RSAs have been identified in the resource sharing plan, a proposal is developed by the MTF. Along with the purpose of the resource sharing proposal, estimated resource requirements (personnel, equipment and supplies) as well as workload and cost/expense data are provided. After the proposal is signed by the MTF Commander, a standardized Resource Sharing Financial Analysis Worksheet is initiated.

C. TYPES OF RESOURCE SHARING AGREEMENTS

Under the MCSCs, RSAs can be either internal or external agreements.

1. Internal Resource Sharing Agreements

With internal resource sharing, the TRICARE contractor provides civilian personnel, equipment or supplies to augment the MTF's resources and enhance the capability to provide health care to beneficiaries within the MTF. The TRICARE contractor pays the costs for the civilian personnel, equipment and supplies, but avoids the institutional costs. The cost avoidance for the institutional costs is shared between the government and the TRICARE contractor.

Government savings from internal resource sharing accrue in three ways. First, resource sharing investments are part of the TRICARE contractor's bid price. This lowers the initial bid price, as calculated in Section I of Appendix B. Second, if partial workload credit is negotiated in the RSA, the government will realize savings in the bid price adjustment for MTF utilization. This can result in a favorable bid price adjustment for the region. These data are provided in Section II of Appendix B and in Section I of Appendix C. Lastly, the government will also realize any residual savings from the MCSCs risk sharing provisions resulting from a favorable bid price adjustment for the region. Section IV of Appendix B and Section III of Appendix C provides this calculation [Copley, 1998].

2. External Resource Sharing

External resource sharing involves MTF physicians or other military health care professionals providing health care to beneficiaries at civilian health care facilities. The additional costs of civilian providers are avoided. This cost avoidance is shared between the MTF and TRICARE contractor.

Savings from external resource sharing can be realized in the same ways as internal resource sharing, except the initial bid price does not include any external resource sharing provisions. Therefore, the initial bid price is not lowered for this type of resource sharing.

D. FINANCIAL ANALYSIS WORKSHEET (FAW)

The MCSC stipulates that a Financial Analysis Worksheet (FAW) be completed for each proposed RSA. Either the MTF or contractor may prepare other analyses, but the FAW is the official document. The FAW is a government developed spreadsheet to evaluate potential resource sharing opportunities. The worksheet is designed to answer two questions for each resource sharing proposal:

- Is the proposed agreement cost-effective?
- Is the proposed contractor workload credit appropriate?

It is determined to be cost-effective if the sum of the MTF marginal expenses and the contractor's expenses for the proposed agreement are less than the Government's share of the projected CHAMPUS savings.

There are separate FAWs for internal and external resource sharing as illustrated in Appendices B and C, respectively. Both of the worksheets consist of four parts, with the internal resource FAW also having a case page and resource support sections. The case page determines whether or not the proposed resource sharing expenditures are already included in the contractor's aggregate Best and Final Offer (BAFO) spending assumption. The four common parts of the FAWs are the MTF/Contractor Inputs, BAFO Data page, an output page, and a summary page [See Appendix B or Appendix C].

The FAW is to be completed each year for every RSA since the cost-effectiveness of an agreement may change and therefore must be reevaluated.

1. MTF/Contractor Inputs to Resource Sharing Financial Worksheet

The following parts of the input section of the FAW are data entry fields to be completed at the MTF. These are to be reviewed by the OLA and contractor.

- Type of Agreement
- Option Period
- Number of MTF Units Enabled by the Agreement
- Expected Government Risk Sharing Responsibility Percent
- Average Government Cost Per Unit Avoided in CHAMPUS for Care Covered by Agreement
- Expected Contractor Category 8 Expenditures
- Projected MTF Marginal Expenditures
- Contractor Resource Sharing Workload Credit Assumed in Analysis

- Sum of Projected Resource Sharing Expenditures [See Appendix B or Appendix C].

2. Data Assumptions from Contract or BAFO Page

This page is provided by OASD(HA) for each MCSC. The page reflects the original data in the contractor's BAFO. The BAFO Data page includes the following contractor data and assumptions:

- The assumed savings-to-cost ratio used to develop resource sharing savings trend factors
- The number of CHAMPUS eligibles by Active Duty Dependents (ADD) and Non-Active Duty Dependents (NADD)
- The CHAMPUS cost-per-eligible for categories 1-3 inpatient care by ADD and NADD
- The CHAMPUS cost-per-eligible for categories 4-7 outpatient care by ADD and NADD
- The percentage of inpatient costs related to admissions requiring Non-Availability Statements (NASs) during the Data Counting Period (DCP) by ADD and NADD
- The number of NAS-Equivalents Projected in the Request for Proposal (RFP) in the DCP and the opinion periods by ADD and NADD
- The number of CHAMPUS outpatient visits in the DCP by ADD and NADD
- The volume trade-off factor assumed in the contract for outpatient visits (used to calculate the "O" factor)
- The number of MTF outpatient visits (non-OB, non-partnership visits) projected in the DCP and the opinion periods by ADD and NADD
- The TRICARE contractor's proposed profit rate for overall health care costs for each option year

- The contractor's aggregate resource sharing expenditures assumed in the BAFO [See Appendix B or Appendix C]

3. Output Section of Financial Analysis Worksheet

This part of the FAW is an output of the data calculations from the MTF/contractor input page and the BAFO page. There are four common sections of this part of the FAW for both internal and external resource sharing, with the internal FAW consisting of one additional section.

The assumed or estimated resource sharing savings are already reflected in the contractor's proposed bid price for the RSA. This is based on the savings to cost ratio used to develop the resource sharing trend factor in the contractor's BAFO. This section is only in the internal resource sharing FAW.

One of the TRICARE contractor's bid price elements is the expected health care costs. These costs, to be incurred by the TRICARE contractor, are composed of eight categories; three inpatient (categories 1-3), four outpatient (categories 4-7), and a category for other costs (category 8). The health care costs for categories 1-7 are used in the bid price formula. The next section estimates the effect of categories 1-7 on the MTF utilization adjustment in the Bid Price Adjustment formula. This section calculates the "O" factor with and without the proposed RSA and calculates the government savings associated with any partial contractor workload credit. Partial workload credit for the contractor would result in a lower "O" factor due to increased MTF utilization and therefore a lower adjusted bid price.

The actual categories 1-7 TRICARE claims cost section calculates the cost avoidance as a result of the RSA. These costs avoided or savings are based on the projected number of TRICARE admissions and/or outpatient visits avoided as a result of the proposed RSA and the cost of each unit avoided in TRICARE.

The risk sharing impacts section estimates the residual gain in TRICARE under the proposed RSA. It also estimates the government and contractor portions of these gains, since the gains would be subject to risk sharing between the government and the contractor.

The final section provides the results of the analysis to check the contractor workload credit and MHS cost-effectiveness. The result answers the two fundamental FAW questions: whether or not contractor workload credit is appropriate and if the RSA is cost-effective for the government from the MHS perspective. The answers to these questions are automatically determined and presented in the worksheet [See Appendix B or Appendix C].

4. Summary of Results

This is a single page summary report answering the two fundamental FAW questions: appropriate contractor workload credit and government cost-effectiveness. It also provides projected contractor and government gains with the associated rate of return on investment.

The proposed agreement should only be approved if both questions are answered "yes." If the cost-effectiveness question is answered "no," then the MTF and contractor

may reevaluate some of the assumptions on the MTF/contractor input page. If the proposed contractor workload credit is answered "no," the MTF and contractor may renegotiate the workload credit percentage.

If it is not possible to negotiate a "yes" answer to both questions, then the proposed RSA should not be approved unless the OLA determines that compelling circumstances warrant RSA approval [Copley, 1998].

E. WORKLOAD

The workload associated with each RSA is collected and reported by the MTF to the TRICARE contractor, as illustrated in Appendix D. This data is collected by the Medical Expense and Performance Reporting System (MEPRS) and the Composite Health Care System (CHCS). The MTF and TRICARE contractor mutually agree upon the workload reporting. The workload reported includes the number of outpatient visits and admissions which would not have been accomplished without the RSA. This RSA recaptured workload is the Attributed Resource Sharing Workload. ADD beneficiaries and NADD beneficiaries are separated. The credited workload is defined as a percentage of the Attributed Resource Sharing Workload as specified in the RSA.

This credited workload is to be reported to the contractor by the 10th of every month for the previous month's workload and must be certified by the MTF Commander. The contractor then has the remainder of the month to report the workload to the TRICARE Management Activity and OLA. The workload is reconciled and audited by

an independent Certified Public Accounting (CPA) firm. The CPA firm conducts an Agreed-Upon Procedure review of the workload credit count procedures [Chiang, 1998].

F. RETROSPECTIVE COST ANALYSIS

After completing an option year, the MCSC stipulates that the TRICARE contractor perform a retrospective cost analysis on all RSAs which were functioning for the entire option year. They utilize as much of the year's actual data as possible. Due to delays in cost data processing, the contractor uses annualized data where necessary to project yearly savings for each RSA. This report is submitted to the Lead Agent and appropriate MTF [Copley, 1998]. An independent auditor reviews all the TRICARE contractor's data collection and analysis procedures.

G. MONITORING OF RESOURCE SHARING AGREEMENTS

Since the RSAs cost-effectiveness is based on estimates and assumptions, it is very important that the RSAs are continually monitored to ensure that they are indeed cost-effective. The MTFs should frequently compare the actual and expected RSA workload to evaluate cost savings.

The OLA coordinates and monitors the RSA expenses, claims and workload generated for all of the MTFs within its region. The OLA uses the FAW and several metrics to track the RSAs' performance [Copley, 1998]. The OLA encourages the MTFs to compare actual workload to the forecasted workload to evaluate variances, spot trends and reevaluate the RSA.

H. SUMMARY

This chapter described Resource Sharing Agreements and the associated reporting and analysis. The workload and cost estimates are analyzed prior to implementing a RSA and must show that it would reduce in costs. After a RSA is utilized, ongoing workload tracking and cost analyses ensure that the RSA is a cost savings venture. Otherwise, the RSA is terminated.

Although resource sharing lowers MHS costs, the MHS's shares these savings with the TRICARE contractor through RSAs.

The next chapter will discuss and display case study data and analysis from HSR10 RSAs. Estimated cost analysis, retrospective cost analysis and workload data will be included in this analysis

IV. DATA PRESENTATION AND ANALYSIS

This chapter will present data collected for a case study of ten RSAs within HSR10 for option period two, the second year of the MCSC. It will also analyze the data reported by the TRICARE contractor, Foundation Health Federal Services, Inc. (FHFSI).

There are two sets of data: the comparative cost analysis for the actual and projected yearly savings, and the retrospective cost analysis for the associated RSAs. The monthly resource sharing workload report will also be reviewed.

A. COST ANALYSIS SUMMARY

The cost analysis summary is an estimated yearly savings for each RSA prepared and reported by FHFSI. These estimates are initially developed from the data and assumptions from the RSA proposal and FAW. There are three basic sections to the cost analysis summary: costs avoided, costs incurred and estimated government savings. The estimated and reported resource sharing visits are also examined. While the total cost analysis conducted by FHFSI is several pages, only the results rolled up into the summary sheets will be reviewed. This data is displayed in Table 2 (page 44).

1. Costs Avoided

This section estimates the costs for TRICARE Standard and for contracted services for the TRICARE Prime and TRICARE Extra programs in the absence of the

RSAs. The TRICARE Standard costs avoided is the estimated expense to TRICARE for providing services for TRICARE Standard beneficiaries without the RSAs. The calculation of the predicted workload times the TRICARE allowable rate less the beneficiaries' copayment is utilized to determine the Standard costs. The contract services amount represents the estimated cost for TRICARE Prime and TRICARE Extra beneficiaries without the RSAs. The total cost avoided is the recaptured workload savings as the result of implementing RSAs. It assumes 20 percent of the RSA workload will be TRICARE Standard beneficiaries and the other 80 percent would be TRICARE Prime and Extra beneficiaries. The estimated annual total cost avoided is 20 percent of Standard cost plus 80 percent of the contracted cost. The retrospective cost analysis uses the same calculation methodology but with actual workload data and updated TRICARE allowable rates.

The case study initial estimate for total Standard costs was \$3,103,528: the initial estimate was \$2,603,842 for the contracted services. By using the formula $(3,103,528 \times .20) + (2,603,842 \times .80)$, the total estimated cost avoidance is calculated to be \$2,703,779. The estimated annual retrospective cost analysis summary figures were \$2,293,079 for Standard, \$1,935,063 for contracted and \$2,006,647 for the total costs avoided.

Comparing the actual and estimated results, actual TRICARE Standard is \$810,449 below the expected cost; the actual contracted cost was \$668,779 lower than expected; the actual total costs avoided was \$697,132 less than initially estimated. The retrospective cost avoided figures were all 74 percent of the estimated cost savings. Two

of the ten RSAs actually had greater than estimated cost savings, but the other eight RSAs more than offset this favorable result.

2. Costs Incurred

Annual estimates of the costs incurred by the MTFs and FHFSI are presented individually for each RSA. The sum of these represents the total expected costs incurred for RSAs in the upcoming year. The cost estimates totaled \$389,855 for the MTFs and \$1,056,037 for FHFSI. The total estimated cost was \$1,445,892. The retrospective reported costs were \$234,613 for the MTFs and \$780,128 for FHFSI; the total costs were \$1,014,743. The costs for these RSAs were \$431,149 less than estimated. Specifically, reported costs were \$155,242 lower than expected for the MTF, and \$275,908 lower than expected for the FHFSI. This equates to a 30 percent reduction from the estimated cost. Again, two of the RSA's had retrospective costs exceeded their beginning estimate.

3. Estimated Government Savings

The estimated government savings are the total costs avoided less the total costs incurred. This represents the estimated RSA savings. The total estimated government savings for these ten RSAs was \$1,257,886. The retrospective government savings, however, were \$839,867. This is \$418,019 less than first estimated. Only 67 percent of the estimated government savings were realized.

4. Resource Sharing Visits

The number of ADD and NADD patient visits is the estimated annual workload for each of the RSAs. The total number of resource sharing visits is first calculated using the MTF provided workload data for the RSA provided service. The retrospective visit count is based on the first nine months of the option year.

The retrospective resource sharing visits were projected to be only 80 percent of the initial estimate, 17,173 actual visits versus 21,370 expected visits. This decrease in workload could be one reason for the decrease in estimated savings.

B. RESOURCE SHARING ACTIVITY REPORT

The TRICARE contractor produces monthly resource sharing activity reports for all of the RSAs. This report relates expenses, hours worked by TRICARE contractor provided personnel, and workload in outpatient visits, admissions and other procedures. Much of the reported data comes from the MTF monthly resource sharing workload report. The summary data for the ten RSAs in this case study are displayed in Table 3 at the end of the chapter (page 45).

1. Expenses

The contractor reports expenses for each RSA. These expenses are for patient TRICARE claims for the care rendered under the RSA, and for other RSA related expenses including supplies and equipment.

This reported data shows a downward trend. The expenses at the beginning of the first option period in April 1996 were \$130,273; the expenses in March 1998, the end of the second option period, total only \$74,007. Downward trends in total expenses are the objective of any cost reduction program. Figure 2 graphically which illustrates this trend.

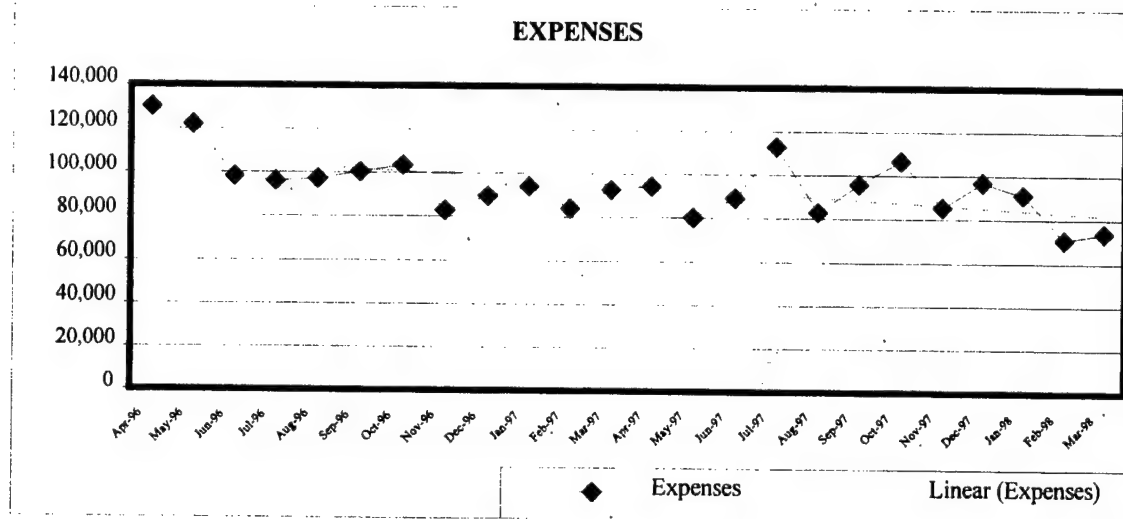


Figure 2. Monthly expenses for April 1996 to March 1998

Using Excel, a multiple linear regression analysis was performed, with the summary results displayed in Table 4 at the end of the chapter (page 46). As a result of the analysis, the monthly RSA expenses can be predicted for the region by using the formula displayed in Figure 3 below. The number of ADD admissions and Other Procedures were statistically insignificant.

$\hat{Y}_{\text{expenses}} = 545.6807 + 11.10755X_1 + 20.20401X_2 + 25.84605X_3 + 7027.929X_4$
<p>Where,</p> <p>$\hat{Y}_{\text{expenses}}$ = Predicted Monthly Expenses</p> <p>X_1 = the number of hours worked by contractor personnel</p> <p>X_2 = The number of ADD outpatient visits for the month</p> <p>X_3 = The number of NADD outpatient visits for the month</p> <p>X_4 = The number of NADD admissions for the month</p>

Figure 3. Multiple regression equation for predicting monthly RSA expenses.

The slope of the number of contractor work hours is 11.10755. This means that the total monthly expenses will increase by approximately \$11.11 for each hour worked. The monthly expenses will increase by about \$20.20 for every ADD outpatient visit, \$25.85 for every NADD outpatient visit, and \$7,027.93 for every ADD admission. Knowing the source of the RSA expenses by these categories could help the MTF and OLA in their decision making process and for predicting expenses.

Comparing the expenses for the first and second years of the RSA indicates that the net annual decrease was only \$111,424. This is a 10.31 percent decrease.

2. Hours

The hours reported are the hours worked by contractor provided personnel under the RSAs. The report breaks down the hours by personnel category (e.g., physician, registered nurse, clerical, etc.).

The combined hours for the case study RSAs also shows a decreasing trend, with considerable variations around the trend line. Figure 4 displays this trend.

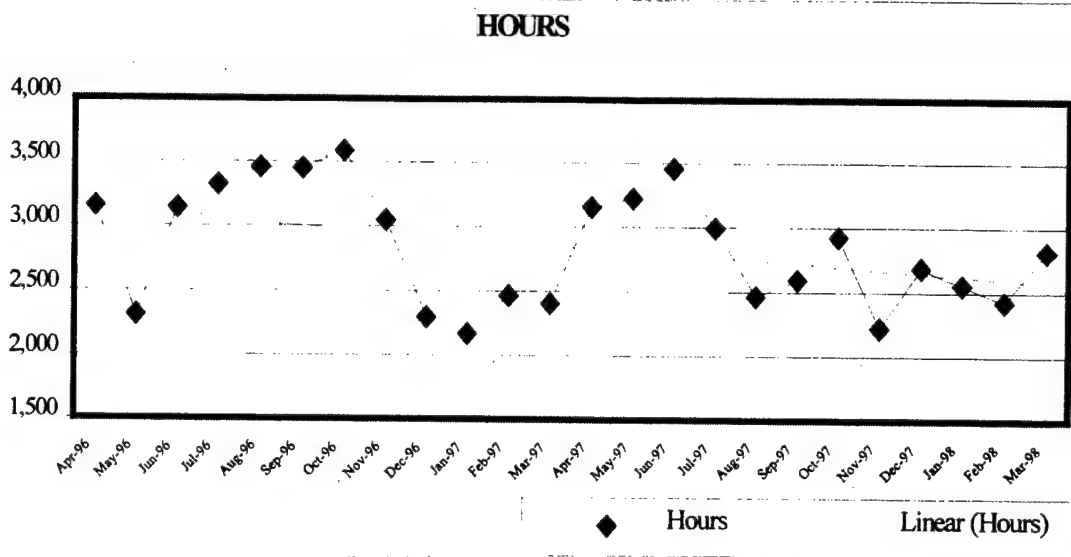


Figure 4. Monthly number of contractor personnel work hours reported.

Using regression analysis (summary results displayed in Table 5, page 47, the monthly RSA contractor hours worked can be predicted for the region using the formula displayed in Figure 5 below. Low statistical significance for ADD and NADD admissions suggested these variables be removed from the model.

$$\hat{Y}_{\text{hours}} = 76.56262 + 0.740613X_1 + 0.829214X_2 + 1.325833X_3$$

Where,

\hat{Y}_{hours} = Predicted monthly hours worked by contractor personnel

X_1 = The number of ADD outpatient visits for the month

X_2 = The number of NADD outpatient visits for the month

X_3 = The number of monthly Other Procedures performed

Figure 5. Multiple regression equation for predicting monthly contractor work hours.

The number of contractor work hours can be explained by ADD and NADD outpatient visits as well as the number of Other Procedures. NADD outpatient visits apparently take longer than ADD outpatient visits. On average, each NADD outpatient

visit takes about 0.83 hours or 5 minutes longer than ADD outpatient visits (0.74 hours). Other Procedures have an even greater effect on the number of contractor work hours, almost 1 hour and 20 minutes per procedure (1.33 hours). Although Other Procedures don't have a direct effect on total expenses, they have a significant effect on the number of hours. This effect on hours may indirectly increase total expenses.

The total contractor hours for the RSAs was 34,823 in the first year and 33,523 for the second year. The number of contractor hours worked decreased by 3.88 percent or 1,300 in the second year .

3. Outpatient Visits

ADD and NADD beneficiary outpatient visits are reported by each RSA. These visits represent the workload that has been performed under the RSA. As stated earlier, the NADD outpatient visits take longer and are more expensive than ADD outpatient visits.

The decreasing workload is illustrated in Figure 6.

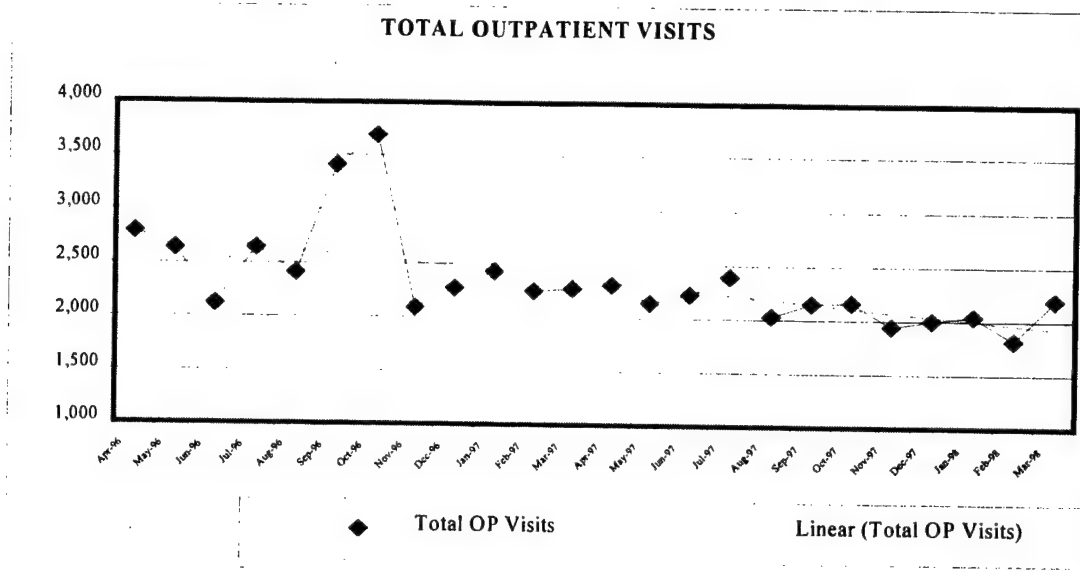


Figure 6. Total monthly outpatient visits for the period of April 1996 to March 1998

The total number of ADD outpatient visits went from 17,439 in the first year to 13,740 in the second year, a decrease of 5,736 or 32.9 percent. NADD outpatient visits also decreased by 1,897 (13.9%) from 13,600 in the first year to 11,703 in the second year. The total number of outpatient visits decreased by 21.99 percent or 5,596 visits.

4. Admissions

There were very few ADD and NADD admissions reported for the RSAs, and no analysis was conducted. There were only 22 admissions for the two year period was only 22 compared to 56,482 total outpatient visits. However, using the predicted expense formula in Figure 3, these 22 admissions increased the total expenses by an estimated \$154,614.46.

Comparing the first and second year's workload, the annual admissions fell by 12, from 17 to 5. This represents a 70 percent decrease in annual admissions.

5. Other Procedures

The other procedure count includes of procedures conducted by paraprofessional contractor personnel rather than a physician or professional medical personnel. These include such things as mammography procedures performed as the result of a RSA.

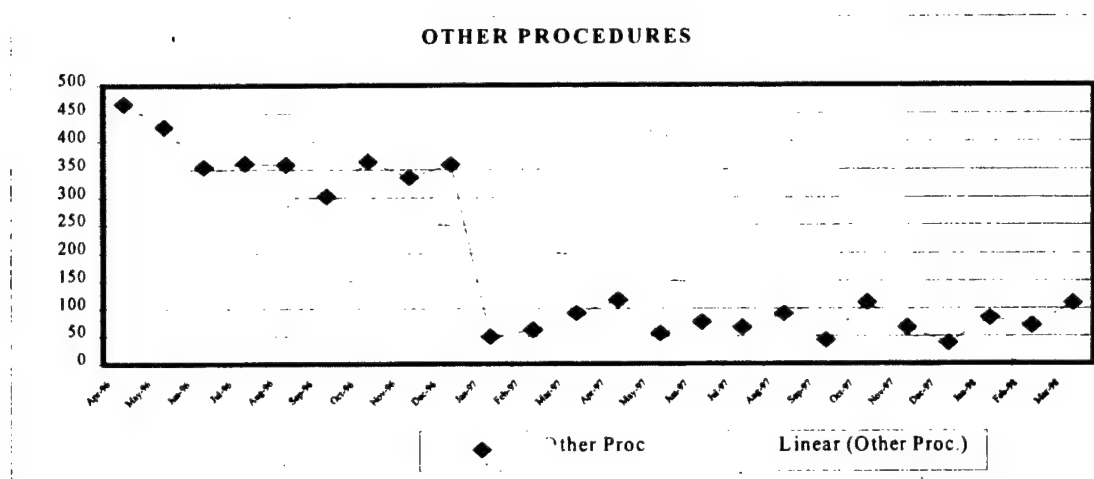


Figure 7. The Number of Reported Other Procedures from April 1996 to March 1998.

The annual number of Other Procedures performed also decreased from the first to the second year of the RSA. There was a reduction of 284.20 percent or 2,609 visits annually. While the data in Figure 7 illustrates an overall decreasing trend over the two option periods, the number of Other Procedures has leveled since January 1997.

C. SUMMARY

This chapter discussed and displayed case study data and analysis from HSR10 RSAs. The actual estimates were consistently lower than the initial predictions. These over estimations totaled \$697,132 for costs avoided, \$431,149 for costs incurred, and \$418,019 for the total estimated government savings. Despite these inaccurate estimates, there was still \$ 839,867 in reported government savings.

The workload has been decreasing since the beginning of the TRICARE contract in this region. This may explain the shortfall in government savings. The expenses and number of hours show a decreasing trend as the workload falls. Total expenses have been reduced by 10.31 percent or \$111,424; however, the workload has decreased at a much greater rate, 21.99 percent, 240 percent and 284.20 percent for total outpatient visits, admissions and other procedures, respectively. Total hours has also dropped, but only by 3.88 percent from the first to the second year.

Two multiple regression analyses were performed, one for total expenses and one for the number of hours worked by contractor personnel. Formulas were developed to predict the expenses and hours worked.

The next chapter will present the thesis summary, conclusion, and recommendations for further research.

	Costs Avoided			Costs Incurred			Estimated Govt. Savings
	20% Standard	80% Contracted	Total	MHS/ MTF	FHFSI/ RS	Total	
Estimate	572,043	486,237	503,398	181,151	66,533	247,684	255,714
Post	248,932	211,507	218,972	73,465	37,787	111,252	107,720
Delta	(323,111)	(274,730)	(284,426)	(107,686)	(28,746)	(136,432)	(147,994)
Delta %	44%	43%	43%	41%	57%	45%	42%
Estimate	111,073	94,412	97,744	3,000	52,000	55,000	42,744
Post	12,689	10,786	11,166	0	7,000	7,000	4,166
Delta	(98,384)	(83,626)	(86,578)	(3,000)	(45,000)	(48,000)	(38,578)
Delta %	11%	11%	11%	0%	13%	13%	10%
Estimate	897,978	763,281	790,220	67,609	227,242	294,851	495,369
Post	1,036,613	881,121	912,220	84,880	288,204	373,085	387,098
Delta	138,635	117,840	122,000	17,271	60,962	78,234	(108,271)
Delta %	115%	115%	115%	126%	127%	127%	78%
Estimate	72,597	61,708	63,885	2,488	24,625	27,113	36,772
Post	21,804	18,533	19,187	2,488	17,775	20,263	(1,076)
Delta	(50,793)	(43,175)	(44,698)	0	(6,850)	(6,850)	(37,848)
Delta %	30%	30%	30%	100%	72%	75%	-3%
Estimate	38,304	32,559	33,708	824	26,266	27,091	6,617
Post	91,893	78,109	80,866	824	57,055	57,880	22,986
Delta	53,589	45,550	47,158	0	30,789	30,789	16,369
Delta %	240%	240%	240%	100%	217%	214%	347%
Estimate	47,617	28,407	32,249	310	28	28,492	3,757
Post	48,123	36,483	38,811	112	26	26,685	12,126
Delta	506	8,076	6,562	(198)	(1,609)	(1,807)	8,369
Delta %	101%	128%	120%	36%	94%	94%	323%
Estimate	48,763	41,449	42,912	99	33,215	33,314	9,597
Post	33,622	28,579	29,588	99	11,080	11,179	18,409
Delta	(15,141)	(12,870)	(13,324)	0	(22,135)	(22,135)	8,812
Delta %	69%	69%	69%	100%	33%	34%	192%
Estimate	845,050	718,292	743,644	169,153	328,716	497,869	245,775
Post	544,894	463,160	479,507	72,745	141,284	214,029	265,478
Delta	(300,156)	(255,132)	(264,137)	(96,408)	(187,432)	(283,840)	19,703
Delta %	64%	64%	64%	43%	43%	43%	108%
Estimate	251,653	191,815	203,783	0	128,857	128,857	74,926
Post	161,912	128,078	134,845	0	106,016	106,016	28,829
Delta	(89,741)	(63,737)	(68,938)	0	(22,841)	(22,841)	(46,097)
Delta %	64%	67%	66%	0%	82%	82%	38%
Estimate	218,450	185,682	192,236	(34,779)	140,400	105,621	86,615
Post	92,597	78,707	81,485	0	87,354	87,354	(5,869)
Delta	(125,853)	(106,975)	(110,751)	34,779	(53,046)	(18,267)	(92,484)
Delta %	42%	42%	42%	0%	62%	83%	-7%
Estimate	3,103,528	2,603,842	2,703,779	389,855	1,056,036	1,445,892	1,257,886
Post	2,293,079	1,935,063	2,006,647	234,613	780,128	1,014,743	839,867
Delta	(810,449)	(668,779)	(697,132)	(155,242)	(275,908)	(431,149)	(418,019)
Delta %	74%	74%	74%	60%	74%	70%	67%

Table 2. Summary of Cost Analysis and Retrospective Cost Analysis for Case Study.

Totals	Expenses	Hours	ADD Outpatient Visits	NADD Outpatient Visits	Total Outpatient Visits	Total Admissions	Other Proc.
Option 1 Totals	1,191,929	34,823	17,439	13,600	31,039	17	3,527
Option 2 Totals	1,080,505	33,523	13,740	11,703	25,443	5	918
Grand Totals	2,272,434	68,346	31,179	25,303	56,482	22	4,445

Option Period	Expenses	Hours	ADD Outpatient Visits	NADD Outpatient Visits	Total Outpatient Visits	Total Admissions	Other Proc.
Option 1 Apr-96	130,273	3,161	1,646	1,143	2,789	3	467
May-96	122,208	2,307	1,505	1,132	2,637	2	426
Jun-96	98,464	3,142	1,114	1,008	2,122	2	354
Jul-96	96,254	3,326	1,512	1,134	2,646	0	361
Aug-96	97,258	3,464	1,402	1,012	2,414	0	358
Sep-96	100,311	3,456	2,000	1,410	3,410	0	302
Oct-96	103,618	3,587	2,084	1,607	3,691	2	364
Nov-96	82,975	3,053	1,135	960	2,095	1	336
Dec-96	89,548	2,292	1,263	1,013	2,276	3	358
Jan-97	94,283	2,168	1,334	1,102	2,436	1	49
Feb-97	83,965	2,466	1,243	1,006	2,249	1	61
Mar-97	92,772	2,401	1,201	1,073	2,274	2	91
Option 2 Apr-97	94,342	3,160	1,181	1,129	2,310	0	116
May-97	80,186	3,226	1,179	971	2,150	1	54
Jun-97	89,189	3,463	1,084	1,141	2,225	0	75
Jul-97	112,944	2,999	1,211	1,185	2,396	1	65
Aug-97	82,931	2,464	1,036	999	2,035	0	90
Sep-97	95,960	2,594	1,183	970	2,153	0	43
Oct-97	106,762	2,926	1,187	977	2,164	0	111
Nov-97	85,309	2,219	1,041	905	1,946	0	65
Dec-97	96,996	2,685	1,131	869	2,000	0	37
Jan-98	91,324	2,551	1,188	859	2,047	2	83
Feb-98	70,555	2,422	1,070	752	1,822	1	69
Mar-98	74,007	2,814	1,249	946	2,195	0	110

Table 3. Summary monthly activity report for case study.

SUMMARY OUTPUT						
<i>Regression Statistics</i>						
Multiple R	0.915843					
R Square	0.838769					
Adjusted R Square	0.836024					
Standard Error	4332.579					
Observations	240					
ANOVA						
	<i>Df</i>	<i>SS</i>	<i>MS</i>	<i>F</i>	<i>Significance F</i>	
Regression	4	2.29E+10	5.74E+09	305.6333	7.47E-92	
Residual	235	4.41E+09	18771239			
Total	239	2.74E+10				
	<i>Coefficients</i>	<i>Standard Error</i>	<i>t Stat</i>	<i>P-value</i>	<i>Lower 95%</i>	<i>Upper 95%</i>
Intercept	545.6807	415.7364	1.312564	0.19061	-273.3662	1364.728
Hours	11.10755	1.560314	7.11879	1.31E-11	8.033555	14.18154
ADD	20.20401	3.213155	6.287903	1.55E-09	13.87373	26.53428
Outpatient Visits						
NADD	25.84605	4.62944	5.582975	6.5E-08	16.72554	34.96656
Outpatient Visits						
NADD	7027.929	869.2934	8.084646	3.3E-14	5315.325	8740.534
Admissions						

Table 4. Partial output from Excel for monthly expenses data.

SUMMARY OUTPUT						
<i>Regression Statistics</i>						
Multiple R	0.812324					
R Square	0.659871					
Adjusted R Square	0.655547					
Standard Error	167.2695					
Observations	240					
ANOVA						
	<i>Df</i>	<i>SS</i>	<i>MS</i>	<i>F</i>	<i>Significance F</i>	
Regression	3	12810351	4270117	152.6181	5.42E-55	
Residual	236	6603067	27979.1			
Total	239	19413418				
	<i>Coefficients</i>	<i>Standard Error</i>	<i>t Stat</i>	<i>P-value</i>	<i>Lower 95%</i>	<i>Upper 95%</i>
Intercept	76.56262	15.51272	4.935475	1.51E-06	46.00156	107.1237
ADD	0.740613	0.114376	6.47523	5.44E-10	0.515284	0.965942
Outpatient Visits						
NADD	0.829214	0.177007	4.684647	4.74E-06	0.480499	1.177929
Outpatient Visits						
Other Proc.	1.326833	0.205721	6.449688	16.28E-10	0.92155	1.732116

Table 5. Partial output from Excel for monthly contractor work hours data.

V. CONCLUSIONS AND RECOMMENDATIONS

This chapter answers the primary and subsidiary thesis research questions. It also provides recommendations and identifies areas for further research. The conclusions are based on the literature review, interviews and data analysis.

A. SUMMARY

This thesis briefly examined the reported cost analysis, retrospective analysis and workload for Resource Sharing Agreements as they are used under the MCSC within HSR10. RSA forecasted and reported savings were compared to demonstrate the impact of RSAs and their role in controlling military health care costs. Specifically, this thesis examined the potential for Lead Agent and MTF to monitor and evaluate the RSA for cost-effectiveness after it has been implemented. Furthermore, the monitoring mechanism used in different MTFs was detailed.

Chapter II provided a brief history of managed health care programs in the civilian sector as well as in the military system with TRICARE. The MHS and TRICARE strive to increase access to high quality health care with greater freedom of choice while reducing overall cost.

Chapter III described Resource Sharing Agreements and associated reporting and analysis. The workload and cost estimates are analyzed prior to implementing a RSA and must show that it will reduce costs. After an RSA is implemented, ongoing workload

tracking and cost analyses are conducted to ensure that the RSA is a cost saving venture. Otherwise, the RSA is to be terminated. Although resource sharing seeks to reduce MHS costs, MHS intends to share the savings with the TRICARE contractor through RSAs.

Chapter IV discussed and displayed case study data and analysis from HSR10 RSAs. The actual estimates were consistently lower than what had been predicted initially. These initial estimates included \$697,132 for costs avoided, \$431,149 for costs incurred, and \$418,019 for the total estimated government savings. Despite these inaccurate estimates, \$839,867 in government savings was reported.

Workload has been decreasing since the beginning of the TRICARE contract in this region. This may explain the shortfall in government savings. Expenses and number of hours have a downward trend, consistent with the decreasing workload.

Despite the RSA not achieving the forecasted savings, this program still reduce government costs through lower contract costs and cost reductions from recapturing the TRICARE workload in the MTFs. RSAs are an option for the MTFs to obtain additional resources which provide added health care services and can improve beneficiaries' access to care.

B. CONCLUSIONS

To accomplish the primary and secondary objectives of this thesis, fundamental research questions were developed. The responses to these questions are provided below.

1. Primary Research Question: What is the role of the RSA within the MCSC and how are they being monitored and evaluated for cost-effectiveness?

The RSA is one facet of the MCSC which helps TRICARE to provide consistent, quality, and affordable health care to active duty military members and their beneficiaries, as well as retirees and their beneficiaries. It increases access to health care by increasing the MTFs medical capability.

The TRICARE contractor and OLA use the FAW, Retrospective Cost Analysis and other metrics, to monitor and evaluate the RSAs for cost-effectiveness. The workload and expenses are reported monthly and analyzed annually. Any RSA which is not considered cost-effective to the government at the annual retrospective cost analysis is thoroughly scrutinized to determine if it is still viable.

2. Subsidiary Question #1: What is the purpose of the Resource Sharing Agreements?

As identified in Chapter II, the RSA reduces government health care costs by recapturing the TRICARE workload, i.e., providing health care at the MTF which is less expensive than that provided by civilian practitioners. RSAs allow the MTFs to increase their health care capabilities by augmenting their resources with the TRICARE contractor's resources. The RSA also gives the MTF Commanders new ways to apply resources that will increase quality and improve access to health care at an affordable

cost. Lastly, the MHS reduces costs and the TRICARE contractor profits by sharing in the cost savings.

3. Subsidiary Question # 2: Are TRICARE Resource Sharing Agreements achieving expected cost-efficiency?

The RSAs examined in this thesis are cost-effective but not at the expected rate. As stated in Chapter III, DoD is estimating government savings as a result of RSAs to be about \$36 million over five years. This reevaluation reflects 9 to 24 months of RSA utilization. DoD first estimated the savings to be approximately \$700 million over five years.

The RSAs in Chapter IV were expected to save the government \$1,257,886 in the first two years. However, only \$839,867 in government savings were realized.

4. Subsidiary Question # 3: How is cost-effectiveness defined in Resource Sharing Agreements?

RSA cost-effectiveness is achieved only when government gains are greater than government expenses, yielding a positive rate of return on investment. This figure is calculated in the FAW and retrospective cost analysis. There should be a cost savings to cost expenses ratio of 2.2:1. In short, cost-effectiveness means that a dollar saved is a dollar earned.

5. Subsidiary Question #4: Is there a standardized method for monitoring Resource Sharing Agreements at different Medical Treatment Facilities?

MTFs report the RSA credited workload on a monthly basis. There are, however, no standardized RSA monitoring mechanisms. MTFs lack the standardized mechanisms and often the manpower to conduct analyses. Instead, they rely upon the OLA and TRICARE contractor to perform any necessary analyses.

C. RECOMMENDATIONS FOR FURTHER RESEARCH

The following observations warrant further research:

Standardized analysis and performance metric tools should be developed. The MTFs and Lead Agents should utilize these tools to monitor and evaluate the RSAs. This effort should also determine the information systems required for monitor RSAs.

Changes in the resource sharing should be evaluated with the “revised” financing methodology incorporated in the new MCSC for Regions I, II, and V.

Further incentives could be developed and provided by DoD. These incentives could motivate health care providers to reduce cost, maintain quality and increase access to care.

APPENDIX A. TRICARE RATES³

Active Duty Family Members

	TRICARE Prime E-1 thru E-4	TRICARE Prime E-5 and above	TRICARE Extra	TRICARE Standard
Annual Deductible	None	None	\$150 individual/ \$300 family for E-5 and above; \$50/\$100 for E-4 and below	\$150 individual/ \$300 family for E-5 and above; \$50/\$100 for E-4 and below
Civilian Outpatient Visit	\$6/visit	\$12/visit	15% of negotiated fee	20% of allowable charge
Civilian Inpatient Admission	\$11/day (\$25 minimum)	\$11/day (\$25 minimum)	Greater of \$25 or \$9.90/day	Greater of \$25 or \$9.90/day
Civilian Inpatient Mental Health	\$20/day	\$20/day	\$20/day	\$20/day

Retirees and Their Family Members

	TRICARE Prime	TRICARE Extra	TRICARE Standard (Standard CHAMPUS)
Annual Deductible	None	\$150 individual/ \$300 family	\$150 individual/ \$300 family
Annual Enrollment Fees	\$230/individual \$460/family	None	None
Civilian Provider copays: Outpatient Visit Emergency Care Mental Health Visit	\$12 \$30 \$25	20% of negotiated fees	25% of allowable charges
Civilian Inpatient Cost Share	\$11/day (\$25 minimum)	Lesser of \$250/day or 25% of billed charges plus 20% of allowed professional fees	Lesser of \$360/day or 25% of billed charges plus 25% of allowed professional fees
Civilian Inpatient Mental Health	\$40/day	20% of institutional & professional charges	Lesser of \$137/day or 25% of institutional & professional charges

³ Source: Health Affairs homepage
(<http://www.ha.osd.mil/tricare/beneficiary/trioption.html>)

**APPENDIX B. INTERNAL RESOURCE SHARING FINANCIAL ANALYSIS
WORKSHEET**

A	B	C
1	MTF/CONTRACTOR INPUTS TO INTERNAL RESOURCE SHARING FINANCIAL WORKSHEET	
2	LEAD AGENT REGION 10	
3		
4	BOXED VALUES MUST BE ENTERED FIRST	
5		
6	VARIABLE	VALUE
7		
8	Note: For All Variables, If Proposed Change Will Be Limited To One Setting (Inpatient or Outpatient), Enter	
9	Zeroes for the Other Setting.	
10	PART I. USED FOR BOTH RESOURCE SHARING AND RESOURCE SUPPORT	
11		
12	1. Select Type of Agreement	<input type="text" value="1"/>
13	If Agreement Recaptures New Workload, Enter 1	
14	If Agreement Converts Partnership Agreement that Existed in DCP, Enter 2	
15	If Agreement Replaces Lost Provider That Existed in DCP, Enter 3	
16		
17	2. If Agreement Converts Inpatient Partnership Agreement that Existed in DCP (2 Is Selected Above for Factor 1), Were CHAMPUS Admissions Counted in the DCP Data? If Yes, Enter Y. If No, Enter N. (If the Answer is No, the Contractor's Return on Investment Should Be Approximately Equal to Zero.)	<input type="text" value="N"/>
18		
19		
20	3. Option Period	<input type="text" value="5"/>
21		
22	4. Number of MTF Units Enabled By the Agreement in Option Period	
23	(Should Reflect the Number of MTF Units Which Would Not Occur in the Absence of	
24	the Resource Sharing/Resource Support Agreement)	
25		
26	A. MTF Units for Both CHAMPUS and Non-CHAMPUS Eligibles	
27		
28	Inpatient Admissions	ADD <input type="text" value="150"/>
29		NADD <input type="text" value="40"/>
30		
31	Outpatient Visits	ADD <input type="text" value="360"/>
32		NADD <input type="text" value="80"/>
33		
34	B. MTF Units for Non-CHAMPUS Eligibles, If Any	
35		
36	Inpatient Admissions	ADD <input type="text" value="20"/>
37		NADD <input type="text" value="10"/>
38		
39	Outpatient Visits	ADD <input type="text" value="50"/>
40		NADD <input type="text" value="20"/>
41		
42	C. MTF Units for CHAMPUS Eligibles Only (Used in Worksheet)	
43		
44	Inpatient Admissions	ADD <input type="text" value="130"/>
45		NADD <input type="text" value="30"/>
46		
47	Outpatient Visits	ADD <input type="text" value="310"/>
48		NADD <input type="text" value="60"/>
49		
50	5. Expected Government Risk Sharing Responsibility %	<input type="text" value="80%"/>
51	Note: The Government's Risk Sharing Responsibility for Mental Health Resource Sharing Agreements Should Always Be 0%, Due to Guaranteed Capitation Pricing for Mental Health.	
52		
53	Expected Contractor Risk Sharing Responsibility % (100% - Government %)	20%
54		
55	6. Assumed Volume Trade-Off Factor for Workload Expected Under This Agreement	
56		
57	Note: This is Used to Estimate CHAMPUS Avoidance. The VTF's Cannot Be Lower than 1.0. While the VTF Under Resource Sharing/Resource Support is Expected to Be Lower than the VTF for MTF Care Overall, the Following Official DoD VTF Estimates for MTF Care Overall May Be Helpful in Estimating These Inputs:	
58		
59		ADD NADD
60	Inpatient, < Age 65	1.0 1.9

A	B	C
61	Outpatient, < Age 65	1.8 2.2
62	Outpatient, Including Age 65+	1.8 2.8
63		
64	Inpatient Admissions Relevant to Proposed Agreement	ADD 1.0
65		NADD 1.0
66		
67	Outpatient Visits Relevant to Proposed Agreement	ADD 1.2
68		NADD 1.5
69		
70	7. Average Government Cost Per Unit Avoided in CHAMPUS For Care Covered By Agreement	
71	You Can Either Estimate Average Government Costs in the Worksheet (A) or Use Estimates Previously Developed (B). Enter Zeroes in the Boxes for the Method (A or B) Not Used.	
72	The Cost of Workload Provided Under Partnership in the DCP Should Be Based on the Partnership Costs (i.e., Professional Costs Only). The Cost of New Workload Should Be Based on the Full CHAMPUS Cost. Under a Partnership Conversion Scenario, This May Result in a Blended Average Unit Cost, If More Workload is Expected in the Option Period than in the DCP.	
73		
74		
75		
76	A. Estimating Average Government Costs in Worksheet	
77		
78	1. Total Government CHAMPUS Costs for Workload Affected	
79		
80	Inpatient Admissions	ADD \$0
81		NADD \$0
82		
83	Outpatient Visits	ADD \$0
84		NADD \$0
85		
86	2. Total CHAMPUS Units for Workload Affected	
87		
88	Inpatient Admissions	ADD 0
89		NADD 0
90		
91	Outpatient Visits	ADD 0
92		NADD 0
93		
94	B. Using Average Government Cost Estimates Previously Developed	
95		
96	Per Inpatient Admission	ADD \$6,500
97		NADD \$7,500
98		
99	Per Outpatient Visit	ADD \$170
100		NADD \$160
101		
102	C. Average Government Cost Per Unit In CHAMPUS Used in Worksheet	
103		
104	Inpatient Admissions	ADD \$6,500
105		NADD \$7,500
106		
107	Outpatient Visits	ADD \$170
108		NADD \$160
109		
110		
111	PART II. USED FOR RESOURCE SHARING ONLY	
112		
113	8. Expected Contractor Category 8 Expenditure Under This Resource Sharing Agreement	
114		
115	A. Total Contractor Category 8 Expenditure for CHAMPUS and Non-CHAMPUS Eligibles	\$400,000
116		
117	B. Contractor Category 8 Expenditure for Non-CHAMPUS Eligibles, If Any	\$50,000
118		
119	C. Contractor Category 8 Expenditure for CHAMPUS Eligibles Only (Used in Worksheet)	\$350,000
120		
121	9. Projected MTF Marginal Expenditures Under RS Agreement	
122	(See User's Guide for Description of Cost Impacts that Should Be Included)	
123		

	A	B	C
124		A. Total MTF Marginal Expenditures for Both CHAMPUS and Non-CHAMPUS Eligibles	\$75,000
125			
126		B. MTF Marginal Expenditures for Non-CHAMPUS Eligibles, If Any	\$25,000
127			
128		C. MTF Marginal Expenditures for CHAMPUS Eligibles Only (Used in Worksheet)	\$50,000
129			
130	10.	Contractor Resource Sharing Workload Credit Assumed in Analysis (May Need to Be Adjusted on an Iterative Basis Until Worksheet is Finalized)	100%
131			
132			
133	11.	Sum of Projected Resource Sharing Expenditures for Agreements Already Approved--To Be Supplied by Lead Agent	\$5,000,000
134			
135			
136			
137		PART III. USED FOR RESOURCE SUPPORT ONLY	
138			
139	12.	Expected Total Expenditure for MTF Under This Resource Support Agreement (Given Zero Contractor Expenditure), Before Contractor Profit	
140			
141		You Can Either A) Use the Expenditure Assumptions Estimated Above For Resource Sharing For Factors 8 and 9 or B) Enter Different Expenditure Assumptions for Resource Support.	
142		You Do Not Need to Estimate Contractor's Profit for Resource Support; the Resource Support Worksheet Page Automatically Calculates This Amount.	
143			
144		A. Use Expenditure Assumptions Estimated Above for Resource Sharing For Factors 8 and 9 (Before Contractor Profit)	
145			
146			
147		1. MTF Payment for Contractor's Costs	
148			
149		a. Total MTF Payment to Contractor for CHAMPUS and Non-CHAMPUS Eligibles	\$400,000
150			
151		b. MTF Payment to Contractor for Non-CHAMPUS Eligibles, If Any	\$50,000
152			
153		c. MTF Payment to Contractor for CHAMPUS Eligibles Only	\$350,000
154			
155		2. Projected MTF Marginal Expenditures Under RS Agreement	
156			
157		a. MTF Marginal Expenditures for CHAMPUS and Non-CHAMPUS Eligibles	\$75,000
158			
159		b. MTF Marginal Expenditures for Non-CHAMPUS Eligibles, If Any	\$25,000
160			
161		c. MTF Marginal Expenditure for CHAMPUS Eligibles Only	\$50,000
162			
163		3. Expected Total Expenditure for MTF Under Resource Support Agreement	
164			
165		a. Total MTF Expenditure for CHAMPUS and Non-CHAMPUS Eligibles	\$475,000
166			
167		b. MTF Expenditure for Non-CHAMPUS Eligibles, If Any	\$75,000
168			
169		c. MTF Expenditure for CHAMPUS Eligibles Only	\$400,000
170			
171		B. Enter Different Expenditure Assumptions for Resource Support (Before Contractor Profit)	
172			
173		1. MTF Payment for Contractor's Costs	
174			
175		a. Total MTF Payment to Contractor for CHAMPUS and Non-CHAMPUS Eligibles	
176			
177		b. MTF Payment to Contractor for Non-CHAMPUS Eligibles, If Any	
178			
179		c. MTF Payment to Contractor for CHAMPUS Eligibles Only	\$0
180			
181		2. Projected MTF Marginal Expenditures Under RS Agreement	
182			
183		a. MTF Marginal Expenditures for CHAMPUS and Non-CHAMPUS Eligibles	
184			
185		b. MTF Marginal Expenditures for Non-CHAMPUS Eligibles, If Any	
186			

	A	B	C
187		c. MTF Marginal Expenditure for CHAMPUS Eligibles Only	\$0
188			
189		3. Expected Total Expenditure for MTF Under Resource Support Agreement	
190			
191		a. Total MTF Expenditure for CHAMPUS and Non-CHAMPUS Eligibles	\$0
192			
193		b. MTF Expenditure for Non-CHAMPUS Eligibles, If Any	\$0
194			
195		c. MTF Expenditure for CHAMPUS Eligibles Only	\$0
196			
197		C. Expenditure Assumptions for Resource Support Used in Worksheet (Before Contractor Profit)	
198			
199		1. MTF Payment for Contractor's Costs	
200			
201		a. Total MTF Payment to Contractor for CHAMPUS and Non-CHAMPUS Eligibles	\$400,000
202			
203		b. MTF Payment to Contractor for Non-CHAMPUS Eligibles, If Any	\$50,000
204			
205		c. MTF Payment to Contractor for CHAMPUS Eligibles Only (Used in Worksheet)	\$350,000
206			
207		2. Projected MTF Marginal Expenditures Under RS Agreement	
208			
209		a. MTF Marginal Expenditures for CHAMPUS and Non-CHAMPUS Eligibles	\$75,000
210			
211		b. MTF Marginal Expenditures for Non-CHAMPUS Eligibles, If Any	\$25,000
212			
213		c. MTF Marginal Expenditure for CHAMPUS Eligibles Only (Used in Worksheet)	\$50,000
214			
215		3. Expected Total Expenditure for MTF Under Resource Support Agreement	
216			
217		a. Total MTF Expenditure for CHAMPUS and Non-CHAMPUS Eligibles	\$475,000
218			
219		b. MTF Expenditure for Non-CHAMPUS Eligibles, If Any	\$75,000
220			
221		c. MTF Expenditure for CHAMPUS Eligibles Only (Used in Worksheet)	\$400,000

	A	B	C	D	E	F	G
1	DATA AND ASSUMPTIONS FROM CONTRACT OR BAFO—PROVIDED BY DoI						
2							
3							
4							
5							
6							
7	REGIONAL VARIABLE	DCP	OPTION 1	OPTION 2	OPTION 3	OPTION 4	OPTION 5
8							
9	Assumed Gross Savings:Cost Ratio		2.20	2.20	2.20	2.20	2.20
10	For Resource Sharing Used to Develop						
11	Resource Sharing Savings Trend Factors						
12							
13	Number of CHAMPUS Eligibles						
14	ADD	78,660	68,573	65,902	64,210	63,864	63,845
15	NADD	140,490	137,914	137,046	136,582	136,421	136,409
16							
17	[(M x P x Q) + (M x R x S) +						
18	(M x T x U)] for Cat. 1-3 Total						
19	ADD		\$258.53	\$257.36	\$263.65	\$272.50	\$282.64
20	NADD		\$194.48	\$190.77	\$193.70	\$199.09	\$205.98
21							
22	[(M x P x Q) + (M x R x S) +						
23	(M x T x U)] for Cat. 4-7 Total						
24	ADD		\$220.74	\$223.36	\$233.67	\$246.73	\$261.49
25	NADD		\$291.89	\$289.25	\$297.89	\$310.37	\$325.42
26							
27	NAS % of DCP Inpatient Costs						
28	ADD	52%					
29	NADD	27%					
30							
31	Number of NAS-Equivalents						
32	Projected in RFP						
33	ADD	4,812	3,143	3,016	2,877	2,862	2,861
34	NADD	3,681	4,622	4,554	4,501	4,496	4,496
35							
36	CHAMPUS Outpatient Visits in						
37	the DCP						
38	ADD	222,499					
39	NADD	415,332					
40							
41	Volume Trade-Off Factor Assumed						
42	In Contract For Outpatient Visits						
43	(Used to Calculate "O" Factor)						
44	ADD	1.80					
45	NADD	2.80					
46							
47	Number of MTF Outpatient Visits						
48	(Non-OB, Non-Partnership)						
49	Projected in RFP						
50	ADD	339,214	237,505	225,154	224,832	223,931	223,846
51	NADD	650,449	408,955	398,418	410,513	414,029	414,249
52							
53							
54	Proposed Profit Rate for		3.50%	3.53%	3.56%	3.57%	3.58%
55	Overall Health Care Costs						
56							
57	Contractor's Aggregate Resource		\$12,309,536	\$12,736,169	\$13,553,047	\$14,460,802	\$15,346,047
58	Sharing Expenditures Assumed in BAFO						

A	B	C	D	E
INTERNAL RESOURCE SHARING FINANCIAL ANALYSIS WORKSHEET				
LEAD AGENT REGION 10				
1	I. Assumed Resource Sharing Savings Already Reflected in Proposed Bid Price Assumptions			
2				
3				
4				
5	I.			
6				
7				
8	A.	Expected Contractor Category 8 Expenditures for CHAMPUS Eligibles Under This Resource Sharing Agreement		\$350,000
9	B.	Are Proposed Savings Already Included in Contractor's BAFO?		YES
10				
11	C.	Assumed Resource Sharing Savings: Cost Ratio Used to Develop Resource Sharing Savings Trend Factor in Original Bid Price for Categories 1-7		2.2
12				
13	D.	Expected Savings in Cat. 1-7 for this Agreement, Consistent with Proposed Savings Trend Factor and Assumed To Be Already Reflected in Original Bid Price for Categories 1-7		\$770,000
14				
15	E.	Net CHAMPUS Savings Assumed To Be Already Reflected in Contractor's BAFO (Categories 1-7 Savings Minus Category 8 Expenditures)		\$420,000
16				
17				
18				
19				
20				
21				
22				
23	II. Impact of Cat. 1-7 Bid Price Adjustment for O Factor			
24				
25				
26				
27				
28				
29	A.	Bid Price Components Unaffected by RS Agreement:		Total
30				
31	1.	Number of CHAMPUS Eligibles in DCP (for the Region)	78,660	140,490
32				
33	2.	Number of CHAMPUS Eligibles in Option Period (for the Region)	63,845	136,409
34				
35	3.	$[(M \times P \times Q) + (M \times R \times S) + (M \times T \times U)]$ for Categories 1-3 Total in Option Period (for the Region)	\$283	\$206
36				
37	4.	$[(M \times P \times Q) + (M \times R \times S) + (M \times T \times U)]$ for Categories 4-7 Total in Option Period (for the Region)	\$261	\$325
38				
39	B.	Inpatient Resource Sharing Agreements: Calculation of O Factor Impact		
40				
41	1.	NAS % of DCP Inpatient Costs (Input for O Factor Formula, for the Region)	52%	27%
42				
43	2.	Number of NAS-Equivalents in DCP (Input for O Factor Formula, for the Region)	4,812	3,681
44				
45	3.	Number of NAS-Equivalents without the Resource Sharing Agreement in Option Period (Input for O Factor Formula, for the Region)	2,861	4,496
46				
47	4.	Inpatient O Factor without this Resource Sharing Agreement in Option Period	0.860910227	1.069646103
48				
49	5.	Number of MTF Admissions of CHAMPUS Eligibles Enabled by the Resource Sharing Agreement in Option Period (Should Reflect the Number of MTF Admissions Which Would Not Occur in the Absence of the Resource Sharing Agreement, According to the Resource Sharing Workload Reporting Guidelines Provided in Section J, Attachment 13)	130	30
50				
51				
52				

A	B	C	D	E
53				
54	6. Number of NAS-Equivalents with the Resource Sharing Agreement in Option Period, Before Contractor Workload Credit	2,731	4,466	NA
55				
56	7. Contractor's Workload Credit for the Resource Sharing Agreement in Option Period (Pending Confirmation of Acceptable Worksheet Results)	100%	100%	NA
57				
58	8. Number of NAS-Equivalents Credited to Resource Sharing Agreement in Option Period	130	30	NA
59				
60	9. Number of NAS-Equivalents with the RS Agreement in Option Period, After Contractor Workload Credit	2,861	4,496	NA
61				
62	10. Inpatient O Factor with this Resource Sharing Agreement in Option Period	0.860910227	1.069646103	NA
63				
64				
65				
66	C. Outpatient Resource Sharing Agreements: Calculation of O Factor Impact			
67				
68	1. CHAMPUS Outpatient Visits in the DCP (Input for O Factor Formula, for the Region)	222,499	415,332	NA
69				
70	2. MTF Outpatient Visits in DCP (Input for O Factor Formula, for the Region)	339,214	650,449	NA
71				
72	3. Number of MTF Outpatient Visits without the Resource Sharing Agreement in Option Period (Input for O Factor Formula, for the Region)	223,846	414,249	NA
73				
74	4. Volume Trade-Off Factor for Outpatient Visits Assumed in Contract	1.8	2.8	
75				
76	5. Outpatient O Factor without this Resource Sharing Agreement in Option Period	1.158366130	1.192450820	NA
77				
78				
79	6. Number of MTF Outpatient Visits By CHAMPUS Eligibles Enabled by the Resource Sharing Agreement in Option Period (Should Reflect the Number of MTF Outpatient Visits Which Would Not Occur in the Absence of the Resource Sharing Agreement, According to the Resource Sharing Workload Reporting Guidelines Provided in Section J, Attachment 13)	310	60	NA
80				
81				
82				
83				
84	7. Number of MTF Outpatient Visits with the Resource Sharing Agreement in Option Period, Before Contractor Workload Credit	224,156	414,309	NA
85				
86	8. Contractor's Workload Credit for the Resource Sharing Agreement in Option Period (Pending Confirmation of Acceptable Worksheet Results)	100%	100%	NA
87				
88				
89	9. Number of MTF Outpatient Visits Credited to Resource Sharing Agreement in Option Period	310	60	NA
90				
91	10. Number of MTF Outpatient Visits with the RS Agreement in Option Period, After Workload Credit	223,846	414,249	NA
92				
93				
94	11. Outpatient O Factor with this Resource Sharing Agreement in Option Period	1.158366130	1.192450820	NA
95				
96	D. Decrease in Cat. 1-7 Bid Price due to O Factor Adjustment, If Any			
97				
98	1. Inpatient CHAMPUS Costs (Categories 1 to 3)	\$0	\$0	\$0
99				
100	2. Outpatient CHAMPUS Costs (Categories 4 to 7)	\$0	\$0	\$0
101				
102	3. Total Change (Categories 1 to 7)	\$0	\$0	\$0
103				
104	III. Impact on Actual Cat. 1-7 CHAMPUS Claims Costs			
105				

	A	B	C	D	E
106					
107					
108	A.	Impact on Inpatient CHAMPUS Claims Costs	ADD	NADD	Total
109					
110	1.	Number of MTF Admissions of CHAMPUS Eligibles Enabled by the Resource Sharing Agreement in Option Period (Should Reflect the Number of MTF Admissions Which Would Not Occur in the Absence of the Resource Sharing Agreement, According to the Resource Sharing Workload Reporting Guidelines Provided in Section J, Attachment 13)	130	30	NA
111					
112					
113					
114					
115	2.	Assumed VTF for Inpatient Resource Sharing Workload Expected Under this Agreement	1.0	1.0	NA
116					
117	3.	Number of Admissions Avoided in CHAMPUS	130	30	NA
118					
119	4.	Average Government Cost Per Unit for Admissions Avoided in CHAMPUS	\$6,500	\$7,500	NA
120					
121	5.	Estimated Categories 1-3 Inpatient CHAMPUS Costs Avoided with Resource Sharing Agreement	\$845,000	\$225,000	\$1,070,000
122					
123	B.	Impact on Outpatient CHAMPUS Claims Costs	ADD	NADD	Total
124					
125	1.	Number of MTF Outpatient Visits By CHAMPUS Eligibles Enabled by the Resource Sharing Agreement in Option Period (Should Reflect the Number of MTF Outpatient Visits Which Would Not Occur in the Absence of the Resource Sharing Agreement, According to the Resource Sharing Workload Reporting Guidelines Provided in Section J, Attachment 13)	310	60	NA
126					
127					
128					
129					
130	2.	Assumed VTF for Outpatient Resource Sharing Workload Expected Under this Agreement	1.2	1.5	NA
131					
132	3.	Number of Outpatient Visits Avoided in CHAMPUS	258	40	NA
133					
134	4.	Average Government Cost Per Unit for Outpatient Visits Avoided in CHAMPUS	\$170	\$160	NA
135					
136	5.	Estimated Categories 4-7 Outpatient CHAMPUS Costs Avoided with Resource Sharing Agreement	\$43,917	\$6,400	\$50,317
137					
138	C.	Estimated Categories 1-7 CHAMPUS Costs Avoided with Resource Sharing Agreement	\$888,917	\$231,400	\$1,120,317
139					
140					
141					
142	IV.	Risk Sharing Impact			
143					
144					
145	A.	Contractor's Resource Sharing Expenditures in Category 8 (For CHAMPUS Eligibles Only)			\$350,000
146					
147	B.	Net Decrease in Actual CHAMPUS Costs (Categories 1-7 Costs Avoided Minus Category 8 Costs)			\$770,317
148					
149	C.	Net Decrease in CHAMPUS Costs Already Reflected in Contractor's Total Bid Price (Includes Effect of Assumed Resource Sharing Expenditures and Savings Trend Factor from BAFO)			\$420,000
150					
151	D.	Decrease in Categories 1-7 Bid Price due to O Factor Adjustment, If Any			\$0
152					
153	E.	Residual Gain in CHAMPUS Categories 1-7 Costs To Be Shared (Actual Net Decrease in Health Care Costs - Savings in BAFO Price - O Factor Adjustment)			\$350,317
154					
155					
156	F.	Expected Government Risk Sharing Responsibility Percentage			80%
157					

	A	B	C	D	E
158		(Lead Agent To Provide Guidance with Input from Contractor for This Assumption to Ensure Consistency within the Region)			
159					
160					
161	G.	Expected Contractor Risk Sharing Responsibility Percentage (Lead Agent To Provide Guidance with Input from Contractor for This Assumption to Ensure Consistency within the Region)			20%
162					
163					
164					
165	H.	Resulting Government Gain Sharing Amount			\$280,253
166					
167	I.	Resulting Contractor Gain Sharing Amount			\$70,063
168					
169					
170					
171	V.	RESULTS OF ANALYSIS: CHECK OF CONTRACTOR WORKLOAD CREDIT AND MHSS COST-EFFECTIVENESS			
172					
173	A.	Contractor Resource Sharing Workload Credit Assumed in Analysis (Above)			100%
174					
175	B.	Contractor's Resource Sharing Expenditures as Percent of Total Expenditures (Contractor + MTF Marginal) (For Information; Not Used in Worksheet Calculations)			88%
176					
177					
178	C.	Analysis of Contractor Return on Investment and Workload Credit:			
179					
180					
181	1.	Contractor's Resource Sharing Expenditures Are These Expenditures and the Resulting Savings Already Reflected in the Contractor's BAFO?			\$350,000 YES
182					
183					
184	2.	Projected Net Contractor Gain from Resource Sharing (Risk Sharing Result), Including Effect of Up-Front Savings Given to Government in Contractor's BAFO (If Relevant): By Crediting the Contractor for Up-Front Savings Given to the Government Below the BAFO Threshold, this Perspective Is Appropriate for Determining Reasonable Workload Credit. This Calculation Reflects the Difference Between the Projected Contractor Savings Under this Proposed Agreement and the Average Savings Rate Assumed in the BAFO. A Negative Value Reflects Contractor Savings Worse than the BAFO Average (or Even an Absolute Loss -- See Next Result Below); a Positive Value Means Savings Better than the BAFO Average. See also the Comparison of Contractor vs. Government Gains Under RS Agreement (Below).			\$70,063
185					
186					
187					
188					
189					
190					
191					
192					
193	3.	Projected Contractor Savings Without Effect of Up-Front Savings Given to Government in Contractor's BAFO: By Treating Up-Front Savings Given to Government as a "Sunk" Investment, Below the BAFO Threshold this Perspective Clarifies the Amount of Up-Front Savings the Contractor Would Actually Achieve from the Proposed Agreement. Even if the Contractor's Gain is Smaller than the Average Savings Assumed in the Contractor's BAFO (a Negative Result in the Previous Line), a Positive Gain in this Line Means the Contractor Would Achieve at Least Some Savings by Implementing this Agreement.			\$154,063
194					
195					
196					
197					
198					
199					
200					
201	4.	Projected Contractor Resource Sharing Return on Investment as Percent of Resource Sharing Expenditures, Including Effect of Up-Front Savings Given to Government in Contractor's BAFO (If Relevant):			20.02%
202					
203					
204	5.	Proposed Profit Rate for Overall Health Care Costs (from Contractor's BAFO)			3.58%
205					
206	6.	Is Proposed Contractor Workload Credit Appropriate?			YES
207		For Agreements Reflecting Expenditures and Resulting Savings Already Included in the Contractor's BAFO (See Part V.C.1), 100 Percent Workload Credit is Appropriate if the MHSS Cost-Effectiveness Requirement is Also Satisfied. The One Exception Is an Inpatient Partnership Conversion When CHAMPUS Admissions Were Not Counted in the DCP for Credit as DCP NAS-Equivalents. In this Case, the Projected Contractor Return on Investment (See Part V.C.4) Should Be Approximately Zero. For Agreements			(See Explanation at Left)
208					
209					
210					

A		B		C	D	E
211	Reflecting Expenditures and Resulting Savings Beyond Those Assumed in the Contractor's BAFO, the Projected Contractor Rate of Return on Investment for Resource Sharing (See Part V.C.4) Should Be Approximately Equal to the Proposed Profit Rate for Overall Health Care Costs (Rounding to the Nearest Full Percentage Point) (See Part V.C.5)					
212						
213						
214						
215	D. Analysis of Cost-Effectiveness for the Government from the MHSS Perspective					
216						
217	1.	Projected MTF Expenditures Under RS Agreement (For CHAMPUS Eligibles Only)				\$50,000
218	2.	Projected Government Gain in CHAMPUS Under RS Agreement, Including Effect of Up-Front Savings (Net Savings in BAFO Price + Savings from O Factor Adjustment + Government Share of Residual CHAMPUS Gain)				\$700,253
219						
220						
221	3.	Net Government MHSS Savings Under RS Agreement, Including Effect of Up-Front Savings Given to Government in Contractor's BAFO				\$650,253
222						
223						
224	4.	Do Government Gains Exceed Government Expenditures?				YES
225		If the Result in Part V.D.3 is a Positive Value, Then Government Gains Exceed Government Costs				
226						
227						
228	E. Bottom Line Comparison of Projected Contractor and Government Gains Under RS Agreement					
229						
230	1.	Total Projected Net Contractor Gain Under Resource Sharing Agreement, Including Effect of Up-Front Savings Given to Government (If Relevant)				\$70,063
231						
232	2.	Total Projected Net Government Gain Under Resource Sharing Agreement, Including Effect of Up-Front Savings Given to Government (If Relevant)				\$650,253
233						
234						
235						
236	NOTE: TERMS OF PROPOSED AGREEMENT SHOULD ONLY BE APPROVED IF THE RESPONSES TO PART V.C.6 AND V.D.4 ARE BOTH "YES."					
237	IF THE RESPONSES TO BOTH QUESTIONS (PARTS V.C.6 AND V.D.4) ARE NOT "YES," THEN THE PROPOSED AGREEMENT SATISFIES BOTH REQUIREMENTS.					
238	CREDIT SHOULD BE ADJUSTED ON AN ITERATIVE BASIS UNTIL THE PROPOSED AGREEMENT SATISFIES BOTH REQUIREMENTS.					
239	IF THIS IS NOT POSSIBLE, GIVEN ALL OF THE OTHER INPUT ASSUMPTIONS AGREED UPON BY THE MTF COMMANDER AND THE CONTRACTOR, THEN THE PROPOSED RESOURCE SHARING AGREEMENT SHOULD NOT BE APPROVED (UNLESS THE LEAD AGENT DETERMINES THAT THE PROPOSED AGREEMENT STILL WARRANTS APPROVAL DUE TO COMPELLING CIRCUMSTANCES).					
240						
241						
242						

INTERNAL RESOURCE SHARING FINANCIAL ANALYSIS WORKSHEET LEAD AGENT REGION 10

SUMMARY OF RESULTS: RESOURCE SHARING

RESOURCE SHARING (INCLUDING EFFECT OF UP-FRONT SAVINGS UNTIL BAFO THRESHOLD IS EXCEEDED)

A.	Is Proposed Contractor Workload Credit Appropriate?	YES
B.	Do Government Gains Exceed Government Expenditures?	YES
C.	Bottom Line Comparison of Projected Contractor and Government Gains Under Resource Sharing Agreement, Including Effect of Up-Front Savings Given to Government in BAFO (If Relevant)	
	1. Projected Contractor Net Gain Under Resource Sharing Agreement -Rate of Return on Investment	\$70,063 20.0%
	2. Projected Government Net Gain Under Resource Sharing Agreement Rate of Return on Investment	\$650,253 1300.5%
	3. Even if Contractor Net Gain Is Negative, Does Agreement At Least Reduce Contractor's Actual Costs Once Up-Front Savings Are Viewed as "Sunk" (I.e, Does the Agreement Still Benefit the Contractor Compared to No Resource Sharing)?	YES

NOTE: TERMS OF PROPOSED AGREEMENT SHOULD ONLY BE APPROVED BY THE GOVERNMENT IF THE RESPONSES TO QUESTIONS A AND B ABOVE ARE BOTH "YES." IF THE RESPONSES TO BOTH QUESTIONS ARE NOT "YES," THEN THE PROPOSED CONTRACTOR WORKLOAD CREDIT SHOULD BE ADJUSTED ON AN ITERATIVE BASIS UNTIL THE PROPOSED AGREEMENT SATISFIES BOTH REQUIREMENTS. IF THIS IS NOT POSSIBLE, GIVEN ALL OF THE OTHER INPUT ASSUMPTIONS AGREED UPON BY THE MTF COMMANDER AND THE CONTRACTOR, THEN THE PROPOSED RESOURCE SHARING AGREEMENT SHOULD NOT BE APPROVED (UNLESS THE LEAD AGENT DETERMINES THAT THE PROPOSED AGREEMENT STILL WARRANTS APPROVAL DUE TO COMPELLING CIRCUMSTANCES).

	A	B	C	D	E	F
	DETERMINING WHETHER THE PROPOSED RESOURCE SHARING EXPENDITURES ARE ALREADY INCLUDED IN THE CONTRACTOR'S AGGREGATE BAFO SPENDING ASSUMPTION					
1						
2						
3						
4						
5						
6						
7						
8						
9	RESOURCE SHARING					
10						
11	Contractor's Aggregate Resource	\$12,309,536	\$12,736,169	\$13,553,047	\$14,460,802	\$15,346,047
12	Sharing Expenditures Assumed in BAFO					
13						
14						
15	Sum of Projected Resource Sharing	\$0	\$0	\$0	\$0	\$5,000,000
16	Expenditures for Agreements Already					
17	Approved--To Be Supplied by Lead Agent					
18						
19						
20	Is Proposed Resource Sharing	YES	YES	YES	YES	YES
21	Agreement Already Included in					
22	the Contractor's Aggregate BAFO					
23	Spending Assumptions?					
24						
25						

**APPENDIX C. EXTERNAL RESOURCE SHARING FINANCIAL ANALYSIS
WORKSHEET**

	A	B	C
1	MTF/CONTRACTOR INPUTS TO EXTERNAL RESOURCE SHARING FINANCIAL WORKSHEET		
2	LEAD AGENT REGION 10		
3			
4	BOXED VALUES MUST BE ENTERED FIRST		
5	VARIABLE		VALUE
6			
7	Note: For All Variables, If Proposed Change Will Be Limited To One Setting (Inpatient or Outpatient), Enter Zeroes for the Other Setting.		
8			
9	1. Select Type of Agreement		1
10	If Agreement Recaptures New Workload, Enter 1		
11	If Agreement Converts Partnership Agreement that Existed in DCP, Enter 2		
12	If Agreement Replaces Lost Provider That Existed in DCP, Enter 3		
13			
14	2. If Agreement Converts Partnership Agreement that Existed in DCP (2 is Selected Above for Factor 1), Were CHAMPUS Admissions Counted in the DCP Data? If No, the Contractor's Return on Investment Should Be Approximately Equal to Zero.		N
15			
16	3. Option Period		1
17			
18	4. Number of External Resource Sharing Units Enabled By the Agreement in Option Period		
19			
20	A. External Units for Both CHAMPUS and Non-CHAMPUS Eligibles		
21			
22	Inpatient Admissions	ADD	140
23		NADD	30
24			
25	Outpatient Visits	ADD	25
26		NADD	20
27			
28	B. External Units for Non-CHAMPUS Eligibles, If Any		
29			
30	Inpatient Admissions	ADD	20
31		NADD	10
32			
33	Outpatient Visits	ADD	10
34		NADD	5
35			
36	C. External Units for CHAMPUS Eligibles Only (Used in Worksheet)		
37			
38	Inpatient Admissions	ADD	120
39		NADD	20
40			
41	Outpatient Visits	ADD	15
42		NADD	15
43			
44	5. Expected Government Risk Sharing Responsibility %		80%
45	Note: The Government's Risk Sharing Responsibility for Mental Health Resource Sharing Agreements Should Always Be 0%. Due to Guaranteed Capitation Pricing for Mental Health.		
46			
47	Expected Contractor Risk Sharing Responsibility % (100% - Government %)		20%
48			
49	6. Assumed Volume Trade-Off Factor for Workload Expected Under This Agreement		
50	Note: This is Used to Estimate CHAMPUS Avoidance. Given That the Costs Are Already Occurring in CHAMPUS, the VTF's Should Almost Always Be 1.0.		
51			
52			
53	Inpatient Admissions Relevant to Proposed Agreement	ADD	1.0
54		NADD	1.0
55			
56	Outpatient Visits Relevant to Proposed Agreement	ADD	1.0
57		NADD	1.0
58			
59	7. Average Government Cost Per Unit Avoided in CHAMPUS For Care Covered By Agreement		
60			

A	B	C
61	You Can Either Estimate Average Government Costs in the Worksheet (A) or Use Estimates	
62	Previously Developed (B). Enter Zeroes in the Boxes for the Method (A or B) Not Used.	
63	A. Estimating Average Government Costs in Worksheet	
64	1. Total Government CHAMPUS Costs for Workload Affected	
65	Inpatient Admissions	ADD \$0
66		NADD \$0
67	Outpatient Visits	ADD \$0
68		NADD \$0
69	2. Total CHAMPUS Units for Workload Affected	
70	Inpatient Admissions	ADD 0
71		NADD 0
72	Outpatient Visits	ADD 0
73		NADD 0
74	B. Using Average Government Cost Estimates Previously Developed	
75	Per Inpatient Admission	ADD \$6,000
76		NADD \$7,000
77	Per Outpatient Visit	ADD \$150
78		NADD \$140
79	C. Average Government Cost Per Unit In CHAMPUS Used in Worksheet	
80	Inpatient Admissions	ADD \$6,000
81		NADD \$7,000
82	Outpatient Visits	ADD \$150
83		NADD \$140
84	8. Expected Contractor Category 1-7 Expenditure Under This Resource Sharing Agreement	
85	A. Total Contractor Institutional or Other Expenditure for External Resource Sharing Workload	\$450,000
86	B. Contractor Institutional or Other Expenditure for Non-CHAMPUS Eligibles, If Any	\$50,000
87	C. Contractor Institutional or Other Expenditure for CHAMPUS Eligibles Only (Used in Worksheet)	\$400,000
88	9. Projected MTF Marginal Expenditures Under RS Agreement	
89	(See User's Guide for Description of Cost Impacts that Should Be Included)	
90	A. Total MTF Marginal Expenditures for Both CHAMPUS and Non-CHAMPUS Eligibles	\$75,000
91	B. MTF Marginal Expenditures for Non-CHAMPUS Eligibles, If Any	\$25,000
92	C. MTF Marginal Expenditures for CHAMPUS Eligibles Only (Used in Worksheet)	\$50,000
93	10. Contractor Resource Sharing Workload Credit Assumed in Analysis (May Need to Be	90%
94	Adjusted on an Iterative Basis Until Worksheet is Finalized)	
95	11. Sum of Projected Resource Sharing Expenditures for Agreements Already Approved-	\$5,000,000
96	To Be Supplied by Lead Agent	

	A	B	C	D	E	F	G
1	DATA AND ASSUMPTIONS FROM CONTRACT OR BAFO-PROVIDED BY DoD						
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
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48							
49							
50							
51							
52							
53							
54							
55							
56							
57							

B					C	D	E
EXTERNAL RESOURCE SHARING FINANCIAL ANALYSIS WORKSHEET							
LEAD AGENT REGION 10							
1	Impact of Cat. 1-7 Bid Price Adjustment for O Factor						
2							
3							
4							
5							
6							
7							
8							
9	Note: O Factor calculations must be beneficiary-category specific.						
10							
11	Bid Price Components Unaffected by RS Agreement:						
12							
13	Number of CHAMPUS Eligibles in DCP (for the Region)						
14							
15	Number of CHAMPUS Eligibles in Option Period (for the Region)						
16							
17	$[(M \times P \times Q) + (M \times R \times S) + (M \times T \times U)]$ for Categories 1-3 Total in Option Period (for the Region)						
18							
19	$[(M \times P \times Q) + (M \times R \times S) + (M \times T \times U)]$ for Categories 4-7 Total in Option Period (for the Region)						
20							
21	Inpatient External Resource Sharing Agreements: Calculation of O Factor Impact						
22							
23	NAS % of DCP Inpatient Costs (Input for O Factor Formula, for the Region)						
24							
25	Number of NAS-Equivalents in DCP (Input for O Factor Formula, for the Region)						
26							
27	Number of NAS-Equivalents without the External Resource Sharing Agreement in Option Period						
28	(Input for O Factor Formula, for the Region)						
29							
30	Inpatient O Factor without this External Resource Sharing Agreement in Option Period						
31							
32	Number of External Resource Sharing Admissions of CHAMPUS Eligibles Enabled by the Resource Sharing Agreeen						
33	Period						
34							
35	Number of NAS-Equivalents with the External Resource Sharing Agreement in Option Period, Before						
36	Contractor Workload Credit						
37							
38	Contractor's Workload Credit for the External Resource Sharing Agreement in Option Period						
39	(Pending Confirmation of Acceptable Worksheet Results)						
40							
41	Number of NAS-Equivalents Credited to External Resource Sharing Agreement in Option Period						
42							
43	Number of NAS-Equivalents with the RS Agreement in Option Period, After Contractor Workload Credit						
44							
45	Inpatient O Factor with this External Resource Sharing Agreement in Option Period						
46							

B				C	D	E
47	Outpatient External Resource Sharing Agreements: Calculation of O Factor Impact					
48	CHAMPUS Outpatient Visits in the DCP (Input for O Factor Formula, for the Region)			222,499	415,332	NA
49	MTF Outpatient Visits in DCP (Input for O Factor Formula, for the Region)			339,214	650,449	NA
50				237,505	408,955	NA
51	Number of MTF Outpatient Visits without the External Resource Sharing Agreement in Option Period (Input for O Factor Formula, for the Region)					
52	Volume Trade-Off Factor for Outpatient Visits Assumed in Contract			1.8	2.8	
53	Outpatient O Factor without this External Resource Sharing Agreement in Option Period			1.166723147	1.201091634	NA
54	Number of MTF Outpatient Visits By CHAMPUS Eligibles Enabled by the External Resource Sharing Agreement in Option Period (Under External Resource Sharing, This Number Will Always Be Zero Since the Visits Do Not Occur in the MTF)			0	0	NA
55	Number of MTF Outpatient Visits with the External Resource Sharing Agreement in Option Period, Before Contractor Workload Credit			237,505	408,955	NA
56	Contractor's Workload Credit for the External Resource Sharing Agreement in Option Period (Pending Confirmation of Acceptable Worksheet Results)			90%	90%	NA
57	Number of MTF Outpatient Visits Credited to External Resource Sharing Agreement in Option Period			0	0	NA
58	Number of MTF Outpatient Visits with the RS Agreement in Option Period, After Workload Credit			237,505	408,955	NA
59	Outpatient O Factor with this External Resource Sharing Agreement in Option Period			1.166723147	1.201091634	NA
60	Decrease in Cat. 1-7 Bid Price due to O Factor Adjustment, If Any					
61	Inpatient CHAMPUS Costs (Categories 1 to 3)			\$26,371	\$4,008	\$30,380
62	Outpatient CHAMPUS Costs (Categories 4 to 7) (Under External Resource Sharing, This Will Always Be Zero)			\$0	\$0	\$0
63	Total Change (Categories 1 to 7)			\$26,371	\$4,008	\$30,380
64	Impact on Actual Cat. 1-7 CHAMPUS Claims Costs					
65	Impact on Inpatient CHAMPUS Claims Costs			ADD	NADD	Total
66	Number of External Resource Sharing Admissions of CHAMPUS Eligibles Enabled by the Resource Sharing Agreement			120	20	NA
67	Assumed VTF for Inpatient External Resource Sharing Workload Expected Under this Agreement			1.0	1.0	NA

	B				C	D	E
93	Number of Admissions for Which Professional Costs Are Avoided in CHAMPUS						
94	Average Government Cost Per Unit for Admissions for Which Professional Costs Are Avoided in CHAMPUS						NA
95							20
96							\$7,000
97	Estimated Categories 1-3 Inpatient CHAMPUS Costs Avoided with External Resource Sharing Agreement						\$860,000
98							\$140,000
99							
100	Impact on Outpatient CHAMPUS Claims Costs						
101							ADD
102	Number of External Resource Sharing Outpatient Visits By CHAMPUS Eligibles Enabled by the Resource Sharing A						15
103	Option Period						15
104							NADD
105	Assumed VTF for Outpatient External Resource Sharing Workload Expected Under this Agreement						1.0
106							1.0
107	Number of Outpatient Visits for Which Professional Costs Are Avoided in CHAMPUS						15
108							15
109	Average Government Cost Per Unit for Outpatient Visits for Which Professional Costs Are Avoided in CHAMPUS						\$150
110							\$140
111	Estimated Categories 4-7 Outpatient CHAMPUS Costs Avoided with External Resource Sharing Agreement						\$2,250
112							\$4,350
113	Estimated Categories 1-7 CHAMPUS Costs Avoided with External Resource Sharing Agreement						\$722,250
114							\$142,100
115							\$864,350
116							
117	Risk Sharing Impact						
118							
119							
120	Contractor's Institutional and Other Expenditures for External Resource Sharing Workload (For CHAMPUS Eligibles Only)						\$400,000
121							\$464,350
122	Net Decrease in Actual CHAMPUS Costs (Categories 1-7 Costs Avoided Minus Contractor's Expenditures)						
123							
124	Decrease in Categories 1-7 Bid Price due to O Factor Adjustment, If Any						
125							
126	Residual Gain in CHAMPUS Categories 1-7 Costs To Be Shared						
127	(Actual Net Decrease in Health Care Costs - O Factor Adjustment)						
128							
129	Expected Government Risk Sharing Responsibility Percentage						80%
130	(Lead Agent To Provide Guidance with Input from Contractor						
131	for This Assumption to Ensure Consistency within the Region)						
132							
133	Expected Contractor Risk Sharing Responsibility Percentage						20%
134	(Lead Agent To Provide Guidance with Input from Contractor						
135	for This Assumption to Ensure Consistency within the Region)						
136							
137	Resulting Government Gain Sharing Amount						\$347,176
138							
139	Resulting Contractor Gain Sharing Amount						\$86,794

	B	C	D	E
140	RESULTS OF ANALYSIS: CHECK OF CONTRACTOR WORKLOAD CREDIT AND MHSS COST-EFFECTIVENESS			
141				
142				
143				
144				
145	Analysis of Cost-Effectiveness for the Government from the MHSS Perspective			\$50,000
146	Projected MTF Expenditures Under RS Agreement (For CHAMPUS Eligibles Only)			\$377,556
147	Projected Government Gain in CHAMPUS Under RS Agreement (Net Savings in BAFO Price + Savings from O Factor Adjustment + Government Share of Residual CHAMPUS Gain)			\$327,556
148	Net Government MHSS Savings Under RS Agreement			
149				
150				
151				
152				
153				
154				
155	Do Government Gains Exceed Government Expenditures?			
156	If the Result in Part IV.A.3 is a Positive Value, Then Government Gains Exceed Government Costs			
157	YES			
158	Bottom Line Comparison of Projected Contractor and Government Gains Under RS Agreement			
159				\$86,794
160	Total Projected Net Contractor Gain Under External Resource Sharing Agreement			\$327,556
161	Total Projected Net Government Gain Under External Resource Sharing Agreement			
162	NOTE: TERMS OF PROPOSED AGREEMENT SHOULD ONLY BE APPROVED IF THE RESPONSE TO PART IV.A.4 IS "YES."			
163	IF THE RESPONSE TO THIS QUESTION IS NOT "YES," THEN THE PROPOSED CONTRACTOR WORKLOAD CREDIT SHOULD BE ADJUSTED ON AN ITERATIVE BASIS UNTIL THE PROPOSED AGREEMENT SATISFIES THIS REQUIREMENT.			
164	IF THIS IS NOT POSSIBLE, GIVEN ALL OF THE OTHER INPUT ASSUMPTIONS AGREED UPON BY THE MTF COMMANDER AND THE CONTRACTOR, THEN THE PROPOSED RESOURCE SHARING AGREEMENT SHOULD NOT BE APPROVED (UNLESS THE LEAD AGENT DETERMINES THAT THE PROPOSED AGREEMENT STILL WARRANTS APPROVAL DUE TO COMPELLING CIRCUMSTANCES).			
165				
166				
167				
168				
169				

EXTERNAL RESOURCE SHARING FINANCIAL ANALYSIS WORKSHEET **LEAD AGENT REGION 10**

SUMMARY OF RESULTS

A.	Do Government Gains Exceed Government Expenditures?	YES
B.	Bottom Line Comparison of Projected Contractor and Government Gains Under External Resource Sharing Agreement	
	1. Projected Contractor Net Gain Under External Resource Sharing Agreement —Rate of Return on Investment Should Rate of Return Be Approximately Equal to Zero?	\$86,794 21.7% NO
	2. Projected Government Net Gain Under External Resource Sharing Agreement —Rate of Return on Investment	\$327,556 655.1%

NOTE: TERMS OF PROPOSED AGREEMENT SHOULD ONLY BE APPROVED IF THE RESPONSES TO QUESTION A ABOVE IS "YES." IF THE RESPONSE IS NOT "YES," THEN THE PROPOSED CONTRACTOR WORKLOAD CREDIT SHOULD BE ADJUSTED ON AN ITERATIVE BASIS UNTIL THE PROPOSED AGREEMENT SATISFIES THE REQUIREMENT. IF THIS IS NOT POSSIBLE, GIVEN ALL OF THE OTHER INPUT ASSUMPTIONS AGREED UPON BY THE MTF COMMANDER AND THE CONTRACTOR, THEN THE PROPOSED RESOURCE SHARING AGREEMENT SHOULD NOT BE APPROVED (UNLESS THE LEAD AGENT DETERMINES THAT THE PROPOSED AGREEMENT STILL WARRANTS APPROVAL DUE TO COMPELLING CIRCUMSTANCES).

APPENDIX D. RESOURCE SHARING WORKLOAD REPORT

RESOURCE SHARING WORKLOAD REPORT		Prepared by <u>Joyce Johnson</u>	
NAVAL HOSPITAL LEMOORE		Phone <u>(209) 998-2643</u>	
August 1998			
Do not enter data in the red cells.			
Primary Ambulatory Care Clinic			
	Outpatient Visits		Total Workload
Workload:			
Enabled Workload			
a. ADD Beneficiaries	255		255
b. NADD Beneficiaries	209		209
Credited Workload			
a. ADD Beneficiaries	255		255
b. NADD Beneficiaries	209		209
Other Services:			
(Not reported as admissions or visits, such as inpatient visits or procedures.)			
			0
Hours Worked by Resource Sharing Personnel by Type:			Total Hours
a. Physicians			160.00
b. Licensed Nurse Practitioner/Registered Nurse			263.50
c. Medical Assistant			141.25
d. Clerk			295.50
Total			860.25
MTF Certification:			
Certified By _____			
<i>MTF Commander or Designee</i>			
Workload Calculation Per RSA:			
Enabled workload is calculated based on a one-for-one count of CHAMPUS eligible			
Credited workload is 100% of the enabled workload.			

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